University of Alberta

Spirit Winds: A Narrative Inquiry into the Aboriginal Stories of Diabetes

by

Sylvia Sophia Barton

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of Doctor of Philosophy

Faculty of Nursing

Edmonton, Alberta

Spring, 2006

Library and
Archives Canada

Published Heritage
Branch

395 Wellington Street
Ottawa ON K1A 0N4
Canada

Bibliothèque et
Archives Canada

Direction du
Patrimoine de l'édition

395, rue Wellington
Ottawa ON K1A 0N4
Canada

Your file Votre référence
ISBN: 0-494-13934-X
Our file Notre référence
ISBN: 0-494-13934-X

NOTICE:
The author has granted a non-exclusive license allowing Library and Archives Canada to reproduce, publish, archive, preserve, conserve, communicate to the public by telecommunication or on the Internet, loan, distribute and sell theses worldwide, for commercial or non-commercial purposes, in microform, paper, electronic and/or any other formats.

The author retains copyright ownership and moral rights in this thesis. Neither the thesis nor substantial extracts from it may be printed or otherwise reproduced without the author's permission.

AVIS:
L'auteur a accordé une licence non exclusive permettant à la Bibliothèque et Archives Canada de reproduire, publier, archiver, sauvegarder, conserver, transmettre au public par télécommunication ou par l'Internet, prêter, distribuer et vendre des thèses partout dans le monde, à des fins commerciales ou autres, sur support microforme, papier, électronique et/ou autres formats.

L'auteur conserve la propriété du droit d'auteur et des droits moraux qui protège cette thèse. Ni la thèse ni des extraits substantiels de celle-ci ne doivent être imprimés ou autrement reproduits sans son autorisation.

In compliance with the Canadian Privacy Act some supporting forms may have been removed from this thesis.

While these forms may be included in the document page count, their removal does not represent any loss of content from the thesis.

Conformément à la loi canadienne sur la protection de la vie privée, quelques formulaires secondaires ont été enlevés de cette thèse.

Bien que ces formulaires aient inclus dans la pagination, il n'y aura aucun contenu manquant.

Canada

TO

DOUG AND ETHEL,

AND

BUELL AND MAUNA

My family – past

AND

LEE AND MADELEINE

My family - present

Abstract

Diabetes mellitus affects aboriginal peoples disproportionately at a rate two to five times higher, depending on region, than other Canadians. The extent and magnitude of diabetes in Aboriginal Canadians reveal an increasing prevalence across the life span, which includes a significant number living with diabetes as an undiagnosed condition. In response to this epidemic in progress, I conducted a research project in central British Columbia, Canada, in early 2003. The purpose of the study was to understand the aboriginal experience of living with diabetes through personal and human elements, as well as cultural and healing dimensions. Narrative inquiry (Clandinin & Connelly, 2000) based on hermeneutic phenomenological philosophy was the methodology that guided the research, and dialogue and conversation were used to retrieve a storied view of experience. I co-participated with one man and three women of aboriginal ancestry to elicit their life stories and to explore the experiences that were informing their diabetic stories. Ultimately, a window for co-constructing a narrative about diabetes as a process of healing and wellbeing from an aboriginal perspective was explicated.

The dissertation has been prepared using a traditional format and includes eight chapters. The first chapter is informative and narratively autobiographical in situating the study within the three-dimensional narrative inquiry space. The second chapter is a descriptive analysis of the fields of aboriginal diabetes knowledge research that guides the involvement of health professionals in aboriginal diabetes programs of care. In the third chapter, the methods involved in the process of making meaning of experience within aboriginal stories of diabetes are described. In the four findings chapters, an aboriginal self understood through the arrow of time, aboriginal experiences of diabetes understood through a sense of place, diabetes as a gateway to aboriginal healing understood through the inclusion of body, and aboriginal reflections of living with diabetes understood through the interpretation of relationship are revealed. The dissertation concludes with a synthesis and discussion of three overarching interpretations that emerged from the inquiry, including implications for the professional discipline of nursing.

Acknowledgement

I owe a very deep debt of gratitude to a large number of people who helped me during the completion of this dissertation. I wish to express gratitude to the people who were willing to share their experiences and perspectives with me – George, Emilie, Violet, and Hazel. I am forever grateful. You treated me like family and without your genuine interest, authentic commitment, and unwavering generosity, this work would have never evolved. Your trust and your stories will live in my heart forever. Many thanks are due to Dr. Linda Ogilvie, my supervisor, for providing exceptional mentorship. Linda creatively engaged me in scholarly conversations, always respecting and valuing the expertise that I brought to our relationship. I am grateful for her many significant contributions as we traveled and experienced my doctoral journey together. Dr. Jean Clandinin provided invaluable insights during the teaching of her narrative inquiry course and encouraged me to write narratively. I appreciated immensely her belief in my abilities and the meaningful support that was always forthcoming. With deep respect and love I thank you. Dr. Brenda Cameron was a motivating influence on my decision to locate my doctoral study within the arena of interpretive inquiry. I appreciated the hermeneutic phenomenological thoughts that she shared, which were always deep and timely. Dr. George Richardson provided stimulating inquiry into research as a living practice that was relational and thought-provoking. Dr. Judith Mill provided support at crucial intervals, and her work influenced me to consider the cultural context of illness from new perspectives. There were many colleagues in the PhD program, in particular Barbara Astle, Gwen Remple, Lisa Goldberg, Eugenia Urra, and Elizabeth Burgess-Pinto, who provided ongoing friendship and intellectual conversation.

I am grateful to my medical colleagues, Dr. Harvey Thommasen and Dr. Nancy Anderson, who initially invited me to Bella Coola to live out my dissertation work, along with necessary accommodation. As family physicians, they both provided me with the invaluable opportunity to be introduced to very special people living with diabetes, as well as a research environment that contributed to the establishment of trusting and respectful relationships between my participants and me. And I am grateful to my colleagues at the University of Northern British Columbia, who provided ongoing support for my pursuit of doctoral education.

Finally, I acknowledge the support received from my family during my doctoral studies. The most enduring and loving influence throughout this endeavor came from my husband, Lee. His capacity to travel with me, side by side, on this scholarly journey revealed his endless support as I lived out each doctoral phase. I am honored to have been given such a priceless gift. I am truly indebted to his significant contributions to my scholarly development. The encouragement of my close friend, Barbara Astle, as we have lived the doctoral journey together, has been precious. Her husband, William, and daughter, Carmen, have become part of our family in deep and wonderful ways. And to my close friend, Dr. Leslie King, who is my reincarnated Simone de Beauvoir, I am grateful for endless love and encouragement.

Table of Contents

I. CHAPTER ONE - Unfolding Narrative Lives 1
Questions of Meaning, Social Significance, and Purpose 1
Credibility of the Researcher 2
Childhood Reflections of an Indian Presence 3
Justifying the Inquiry 3
Aboriginal Relational Perspectives 5
What the Narrative Inquiry is About 5
Connecting First Nations Stories to My Stories 6
What the Experience of Interest is to Me as a Narrative Inquirer 6
An Academic Story 7
Three-dimensional Narrative Inquiry Space 10
  Interaction – Personal and Social 10
  Continuity – Past, Present, and Future 11
  Situation – Place 11
A New Adoption Story 12

II. CHAPTER TWO - Discovering the Literature 17
Focusing the Review 19
Considering the Empirical Context 19
Approaching the Analytical Review 22
Identifying Aboriginal Ancestry 23
Analyzing Selected Literature 24
Revealing the Cultural Aspects and Gaps 26
Oral Narratives of Story, Connection, and Art 29
Working with Multiplicity 29
The Notion of Coherence 30

III. CHAPTER THREE – Living Out Relational Methods on an Aboriginal Landscape 32
Theoretical Considerations 32
  Sorting Out a Narrative View of Experience 32
  Revealing Meaning in Dialogue and Conversation 33
  Thinking About Research as a Living Practice 35
Practical Field Text-Oriented Considerations 36
  Beginning the Inquiry with Participants 36
  Negotiating Entry into the Field 38
  Relational Background 40
  Collecting the Data 42
  Shifting from Living Stories to Retelling Stories 44
  Being in the Midst of Cultural Narrative Expressions 45
  Creating the Field Texts 46
Interpretive-Analytic Considerations 48
  Moving Back and Forth Between Field Texts and Research Texts 48
  Shaping Field Texts into Research Texts 49

  Experimenting with Writing Interim Research Texts 51
  Settling on the Research Texts as a Final Version 53
Persistent Ethical Considerations 54
  Publishing and Presenting the Research 57
Achieving Rigor 58
Concluding Remarks 59

IV. CHAPTER FOUR - An Aboriginal Diabetic Self: The Arrow of Time 61
Beginning a Journey 61
Sickness from Eating Dangerous Foods 65
An Elder with Spirit in His Body 69
The Good, the Bad, and the Ugly........................ 71
A Life of Fishing and Hunting 73
After My Heart Attack Came Diabetes 77
Times When I Felt Depressed 79
For the Love of Our Children 80
Learning About Diabetes 81
Conversational Layers 83
A New View of Eating 85
Being Caught By the Disease 90
Starting All Over Again 93
Keeping an Eye on Me 94
Stream of Time 99
Cultural Time 102
The Sugar Clock 105
Time at Play 108
  At the Fire Hall 111
  The Hospital 112
Echo of the Past 113
Images of Time 115

V. CHAPTER FIVE - Aboriginal Experiences of Diabetes: The Sense of Place 118
Under the Deep Blue Sky 118
The Wonder of Sacred Places 118
Acting Sick 120
It Was in My Mind 122
A Reflection of Ourselves in Others 123
Entangled Stories 124
Looking After Someone Else More 126
Significant Changes 127
Landscapes of Uncertain Situations 128
Recollecting Childhood Places 131
Family Connections 132
Teaching Our Language 134
Figuring Out What Is Wrong 137

Living in Diabetic Spaces 140
Feeling Well Enough to Keep Busy 141
Changing Our Way of Eating 144
Rethinking What is Good for Us 145
Situation and Experience 147
Gestures of Empathic Imagining 152
Resonance of Lived Space 156
Becoming the Space We Are In 158
Landscapes in Transformation 161

VI. CHAPTER SIX - Diabetes as a Gateway to Aboriginal Healing: The Inclusion of Body 165
Wings of a Humming Bird 165
Multiple Manifestations 169
Knowing What Not to Do 170
Changing Our Ways 172
Diabetes in the Family 174
Things You Just Need to Know 175
What We Eat and How We Live 177
Working in the Hospital 179
Traditional Medicines 181
Keeping Active 184
Living on Fish 186
Early Motherhood 187
The TB Hospital 188
We Were Good Kids 191
Living in the Valley 192
Feeding the Diabetic Body 194
Exercise and Body Weight 199
Bodily Discomfort 202
On Being Itchy 205
Working on the Diabetes 206
Figuring the Diabetes Out 208

VII. CHAPTER SEVEN - Aboriginal Reflections of Living with Diabetes: The Interpretation of Relationship 211
Running Bear 211
Tragic Happenings 213
Sustained Connections 217
Trying to Control Myself 220
Looking After Each Other 223
Relational Secrets 225
Love in the Heart 227
Listening to the Health People 230
Helping Each Other 233
The Grace of an Elder 235

Honoring the Diabetic Self 238
Revealing the Diabetic Self to Others 243
A Diabetic Sense of Community 245
Walking in Both Worlds with the Health People 247

VIII. CHAPTER EIGHT – Finding Harmony: Balancing Diabetes, Culture, and Wellness 252
Cultural Differentiation and the Diabetes Experience 253
An Existential Understanding of Aboriginal Diabetes 259
Authentic Acts of Mutual Respect and Caring 261
Cross-cultural Contributions 264
Professional Contributions 268
Personal Contributions 270
Theoretical Contributions 273
Informing Nursing Practice, Education, and Research 275
Reflecting on Future Nursing Development 278
Conclusion 279

IX. REFERENCES 281

IX. APPENDICES 296
Appendix A: Summary of Methods 296
Information Sheet (Participants) 297
Consent (Participants) 298
Appendix B: Consent (Use of Participant's Name & Community) 299

CHAPTER ONE[1]

Unfolding Narrative Lives

This research project was conceived from an unabated and passionate interest to inquire into how aboriginal people have constructed, or made sense of, who they are in relation to their experience in the world while living with diabetes. We discovered that such experiences were nested in the world of healing and wellbeing, more than they were in the world of chronic illness. Foundational to the work was a realization that what existed in our discovery through narrative inquiry (Clandinin & Connelly, 2000) were creative acts whereby we learned to negotiate a relational process, as well as creative moments that connected our humanness to ourselves and to each other. In other words, we presented each other with opportunities to discover, in the living practice of research (Carson & Sumara, 1997), something that elicited a pouring out of our humanity. And at times as it poured out instantly and unconditionally, it revealed things of importance.

Questions of Meaning, Social Significance, and Purpose

From my experience as an outpost nurse in First Nations communities in British Columbia and the Yukon, Canada, I was troubled by the negative, stereotyped construction of images of aboriginal people by society at large. These were images that perpetuated conceptualizations of aboriginal people's identities and communities as sick, disorganized, and dependent (O'Neil et al., 1999). The work of O'Neil (1986, 1989) was instrumental to me in understanding the importance of *culture-specific analysis* that related to both Canadian Aboriginals and the origins of Canadian health and educational institutions. I became perceptive to the reinforcement of unequal power relationships and justified paternalism that exist in our health care systems. The desire to uncover the creation of new positive constructions of aboriginal people's healing needs and identities that not only contribute to wellbeing, but provide a more balanced perspective of the aboriginal experience of living with diabetes, became the impetus for an inquiry based on the elicitation of stories.

---

[1] *A version of this chapter has been published. Barton 2004. Advanced Journal of Nursing. 45: 519-526.*

As I thought about where to focus my doctoral research, I puzzled over how aboriginal people constructed narratives of themselves in relation to health and illness. Such fascination enticed me to raise questions of meaning about the *storied knowledge landscape* (Clandinin & Connelly, 2000) of aboriginal health in Canadian society that was unreflective of local aboriginal people's stories of diabetes. This concern raised further questions related to the social significance of knowledge generated through narratives that aboriginal people might want to construct about themselves as they live with diabetes. By thinking about the social significance for Canadian society to understand aboriginal stories of diabetes, as well as the creative responses and adjustments that exist in these experiences, I raised questions of purpose. Based on my interactions with First Nations people since 1989, I began to perceive how to open up a *narrative space* whereby understanding and explanation could emerge from *self* stories.

As a lens through which I explored aboriginal knowledge, the experience of living with diabetes required an approach to research that was sensitive to the elicitation of life stories. Further, crucial to interpreting aboriginal experience, such an approach required the utilization of narrative analysis in order to make meaning of the insightful details circumscribed by relationship, history, and landscape, which are formulated by oral narratives through representation, connection, storytelling, and art. As a non-aboriginal researcher, narrative inquiry provided me with an experience of research whereby inquiry into epiphanies, ritual, routines, metaphors, and everyday experiences created a process of reflexive thinking for multiple ways of knowing. And based on the sharing of perspectives, it provided a way to experiment with creating new forms of knowledge by contextualizing diabetes from the experience of myself as a researcher overlapped with the experiences of participants - a reflective practice into a world of cultural wellbeing.

Credibility of the Researcher

As part of a reflexive research process, entwined within the dissertation are *my stories* as researcher and human being, narratives that are intended to assist in deepening the qualitative researcher's experience as data. It is my understanding that narrative inquiry based on hermeneutic phenomenological philosophy recognizes the influence of the researcher on the procedural aspects of an inquiry, as well as on the presentation of text. The ability to describe and interpret my experience was an essential aspect of the research process (Guba & Lincoln, 1989). As a result of being aware of my own potential effect on the data collected, referred to as the problem of reactivity (Hammersley, 1990), and of my social and personal characteristics on data collection (Goffman, 1959), I provide information about me as a narrative inquirer through storied form. It is an aspect of the inquiry that allows "readers to judge the credibility of the research in relation to intellectual rigor, professional integrity and methodological competence, and the influence of experience and background on my approach" (Whitehead, 2004, p. 516). Further, the way in which my self-awareness was raised and how the process and product of a narrative inquiry were documented are described in Chapter Three, "Living Out Relational Methods on an Aboriginal Landscape". I now present an autobiographical story reminiscent of time.

Childhood Reflections of an Indian Presence

In the summer of 1967, I went to an *Indian midden* to be amidst an archeological *dig*. I remember how elated I was, shaking soil too heavy for a handmade sifter. Staring at the beads I had collected, they were remnants of an unknown past. And they were beads that had to do with historical lives where people had gone about everyday living. Sitting in this desecrated place, I imagined myself in this past life at the same time I was aware of my own moment, a fleeting present. In a timeless way, I felt our paths crossing. Light as a feather, I let my thoughts float away as I reflected on an Indian presence.

Justifying the Inquiry

Early in my life, seeds of cultural interest had been sown, as revealed in the previous story. I took particular enjoyment in relating with friends from different countries, and in reading about lives lived in different places. Later, I searched for books written by indigenous authors who used stories to teach about culture, history, environment, and ways of being. Stories that were, also, entertaining. And stories that were sacred, teaching their people how to be humble and respectful human beings. Such relevancy to the development of my own personal philosophy provided a background for thinking about indigenous stories, ways to incorporate storytelling as a methodology, and ways to integrate indigenous stories into health research. In terms of my own inquiry, Smith (1999), a Maori scholar, assisted me to understand criteria for perceiving colonial research through an indigenous perspective:

> From an indigenous perspective [colonial] research is more than just research that is located in a positivist tradition. It is research, which brings to bear on any study of indigenous peoples, a cultural orientation, a set of values, a different conceptualization of such things as time, space and subjectivity, different and competing theories of knowledge, highly specialized forms of language, and structures of power. (p. 42)

In addition, during my doctoral course work, I realized that a potpourri of styles amid an array of qualitative methodologies were contributing to the explorative study of experience. As I studied qualitative research, I became sensitive to and appreciative of how criteria for doing ethnography, phenomenology, action research, or narrative inquiry were finding enduring and overlapping ways to evolve within a shifting realm of interpretive inquiry. It was precisely the highly personalized nature of doing research with people living out lives that resulted in me working with the existence of fluid boundaries between narrative inquiry, hermeneutics, and phenomenology. Retrospectively, such a perspective had a creative way of sparking my research questions and a way of enticing me to puzzle over my inquiries. Since I view all inquiries by nature to be cultural and complex, I found it necessary to be reflexive in my thinking by first exploring the multiple ways qualitative research may be approached.

Similar to other narrative researchers, I sought different forms of interpretive inquiry as possibilities for studying experience. Although I initially laid the ideas and concepts of each approach side by side, my journey took me to puzzle over experience as lived and told in stories. By emphasizing the importance of storytelling, I realized that diabetes as the phenomena of experience could open up explorations from aboriginal perspectives. As Bochner (1997) writes:

> …we do not turn stories into data to test theoretical propositions. Rather, we link theory to story when we think with a story, trying to stay with the story, letting ourselves resonate with the moral dilemmas it may pose, understanding its ambiguities, examining its contradictions, feeling its nuances, letting ourselves become part of the story (Ellis, 1995). We think with a story from the framework of our own lives. We ask what kind of person we are becoming when we take the story in and consider how we can use it for our own purposes, what ethical directions it points us towards and what moral commitments it calls out in us (Coles, 1989). (p. 436)

Since the narrative inquirer takes interest in the ongoing quality of life, I was able to see myself positioned as a researcher alongside my participants on a relational landscape.

Such an approach guided my recognition of indigenous peoples' cultural orientations, sets of values, and different conceptualizations to place, time, and subjectivity. I was better positioned to honor and respect the intermingling of perspectives, such as different and competing theories of knowledge, highly specialized forms of language, and structures of power. Narrative inquiry united both process and product. As a narrative inquirer through process, I was able to co-participate and come to know experience, and through product co-construct stories of experience using text. As Clandinin and Connelly (2000) point out, such inquiry reflects in the writing of the narrative inquirer "a narrative view of experience, with the participants' and researchers' narratives of experience situated and lived out on storied landscapes" (p. 127). As a particular kind of research, metaphorically it was a way for us to peel back the bark of a tree and uncover the multiple layers of interwoven meanings of experience beneath together.

Aboriginal Relational Perspectives

While nursing on the aboriginal landscape, I loved to hear the children's stories when they knocked on my door and we walked to nearby beaches. Caressed by coastal breezes we laughed and played, losing ourselves in a lightness of being. I loved to hear the stories of young girls as their innocence caught the eyes of curious school boys. Giggling and winking, they let me gaze on their sweetness of being. I loved to hear the stories of men and women who spent their days at river camps catching and preparing salmon. Teaching and sharing, they invited me into a generous way of being. I loved to hear the stories of elders who touched my heart with so few words, but said so much. Gentleness and wisdom emanated from their faces and kindness from their hearts, with emotions deep as the sea. Visiting and listening, we blended our ways of knowing - souls dancing in a spirit of being.

What the Narrative Inquiry is About

As revealed in the above story, my inquiry focused on the centrality of understanding relationship as the key to what it was that I did as a narrative inquirer, thereby guiding the doing of the research. As a result of the co-participating and co-constructing nature of the inquiry, I sought to understand the phenomenon of diabetes as experience through the following questions. What stories are aboriginal people constructing about themselves during the experience of living with diabetes? How are aboriginal people constructing their stories of who they are while living with diabetes as a long-term condition?

Given that studies of aboriginal peoples and disease have, in the past, not made sufficient attempts to study the underlying knowledge that is hidden in the aboriginal meaning of diabetes, many stories are yet to be unraveled. The likelihood of such knowledge having implications for theory and social health policy development are great. Although policies that advocate for culturally sensitive approaches comprise one way of approaching aboriginal peoples' health needs, they cannot be applied in isolation of the structural constraints and barriers inherent in colonial health systems. Thus, by having aboriginal people tell their stories of diabetes, provided would be theory into understanding the discourse around a new area of aboriginal health – healing and wellbeing. And this would have implications for practice, research, and policy, which could influence the construction of more positive conceptualizations of aboriginal peoples' identities as they challenge the imbalances and disharmonies of diabetes health.

Connecting First Nations Stories to My Stories

In recalling and recollecting the strong stories of my life, I realize that they nourish and reconstruct all others. First Nations peoples' stories and my nursing stories have entwined to create new ones in the renewal of our lives. Like a meandering river, the currents of life gently nudged us to her shallows and forced us unforeseen into her depths. Trying to understand my location in our overlapping lives, these stories were set in place and time on the fringe of culture where body and spirit unsuspectingly met – stories connecting in intermingling storied minds.

What the Experience of Interest is to Me as a Narrative Inquirer

By considering streams of thought within theory and literature, as well as within the participants' and my own personal stories, I emphasized in my inquiry the significance of four identities in transformation. They are four aboriginal people living with diabetes amidst intersecting, multiple world views and perspectives, whose life narratives link to understandings of aboriginal knowledge as holistic and collective health knowledge. In positioning the inquiry within the scholarly conversations of diabetes research, critical social theory, postcolonial studies, relational literature, and indigenous writings, dialogue framed by considerations for culturally competent scholarship (Meleis, 1996) coalesced in my mind.

The projects of Freire (1973, 1985) and Habermas (1971), for example, bring together some of the most important developments in the understanding of the transformative self, the development of a critical consciousness, and notions of identity formation within dialogue and conversation as acts of collaboration or partnership. In comparing their key contributions to educational theory, their approaches converge to represent a critical theory in action as presented by Morrow and Torres (2002). Using the work of Bhabha (1994) and other postcolonial writers (Thomas, 1994), I examined, critically, the relationship of colonialism to aboriginal health in order to better understand the Canadian context of aboriginal peoples as colonized nations, with implications for the nursing of aboriginal populations. Finally, the work of indigenous scholars (Smith, 1999; Battiste, 2000; and Tafoya, 1995) kept my research approach grounded. They guided my thinking in ways that resulted in appreciating, further, the detail and intricacy within indigenous ways of viewing the world. I began to discover how topics of health, such as the aboriginal experience of diabetes, could be elucidated in ways that revealed, simultaneously, ethical issues relating to cultural pluralism and the development of culturally competent knowledge.

An Academic Story

I came to a further appreciation of the human sciences through narrative inquiry based on hermeneutic phenomenological philosophy in my doctoral studies of nursing and aboriginal health at the University of Alberta. During this time, I reflected on a professional form of living, whereby personal philosophical interpretations associated with a reflective practice are extended deep into a working life. This story reflects aspects and features derived from both realities. It speaks to learning to live in a world that "is given *to* us and actively constituted *by* us" and by "reflecting on it phenomenologically, we may be presented with possibilities of individual and collective self-understanding and thoughtful praxis" (van Manen, 1998, p. xi).

Over the past eight years, I have engaged and thrived on an academic position within a university setting. Such a decision was based on years of fulfillment in the world of nursing that culminated in a desire to integrate scholarship, particularly aboriginal health research, with professorial contributions related to teaching and service. It was a decision that profoundly shaped and influenced an unfolding of a life. Foundational to my career as a nurse, which followed eighteen years of nursing in practice and education, was a desire to continue in the perpetuation of creative acts of meaning and purpose. These are acts that are encountered in the stories that people tell each other, which reveal fundamental elements of healing and wellbeing. And they are acts that embody the collective efforts of people who assist one another to proceed in the world in productive and moral ways, transferring what is known about each other and what is not.

I learned within this context – an academic story – of ways that balance a scholarly approach with creative moments, connecting elemental humanness to myself and others. They were ways of being that resulted in rich experiences, whereby I discovered with other people living out academic stories things that were drawn forth in response to the pouring out of our desires. For to be a nurse, as well as a social scientist, is to search for understanding that exists in the labyrinth of social connections, which leads us to our humanity and wellbeing. And as this desire still pours out of me, instantly and relentlessly, it continues to surprise and reveal things of cultural importance.

As I think about a working life, I puzzle over how I have constructed stories of myself living the practice of an academic. Such contemplation entices me to recall events of meaning about the *storied academic landscape*, and of my own tenure at a university. All is reflective of a deep and satisfying professorial narrative enmeshed with an enriched and grounded personal one. These memories raise further thoughts related to the social significance of university life generated through stories that I have constructed about myself. As I live within a teaching and learning environment, I recognize a context deeply intra-dependent upon acts of sharing in the lives of others. For generated there is the means by which academic relationships address the constant state of renewal and development that originates from a desire to create and exchange valued knowledge. And it is knowledge that filters through our lives, that requires skepticism and judgment to decipher, and that guides the agency we bring to the altering of our existence.

In thinking about the social significance of my life experiences for understanding academic stories as a living practice, as well as the creative responses and adjustments that I have brought to those experiences, I continue to question the purposes of life.

Based on experiences with people working and living in rural and remote, as well as urban, environments, I ponder over what I term a *coherent space*, whereby understanding and explanation in relation to the purpose of life is influenced, in part, by a relationship with a *living place*. Such a perception of location encompasses the taken-for-granted relational connections to human, animate, and inanimate beings and objects, which are represented in personal, scholarly stories. It is the vastness of this relational world that entices me to reflect on what it is I am actually experiencing, as well as what is generated and left behind.

As a researcher in a professional domain such as nursing, I have become more aware of the importance of interpretive models that place being humanly situated central to understanding human beings from an experiential reality point of view. It has also caused me to ask what kind of person I am becoming. At its best, my professional and disciplinary work experience has provided me with insights that have been useable for my own purposes, pointed me in worthwhile ethical directions, and called out in me sound moral commitments. These are things of social importance. And although I look back on my tenure with great satisfaction, it is what I experienced along the way that continues to turn a reflective mind. For I have come to know myself from yet another angle, revealing resilience by which mature threads of character have surfaced in the face of challenging self-imposed responsibilities and expectations.

The type of reflection required in the act of narrative inquiry writing, based on hermeneutic phenomenological philosophy, on the storied meanings and significances of phenomena of daily life is fundamental to researching the aboriginal experience of living with diabetes. On one level this text offers a research approach that is fundamental to the process of pedagogy. It is intended to assist nurses and health professionals "to *act* in the lives [they] live, side by side with [aboriginal people living with diabetes], but then also *wonder*, always wonder whether [they] did it right. We need to *listen* to pedagogy so as to be able to act in a better way pedagogically tomorrow" (van Manen, 1998, p. 149). And on a second level, this text offers a research approach that orients itself through thinking within a three-dimensional inquiry space (Clandinin & Connelly, 2000) to produce "dialogically constructed texts [that] allow us to recognize our lives in the mimicry of stories and conversational anecdotes. Thus, dialogic texts allow for [the creation of] a certain space, a voice, which teaches by its textuality what the sheer content of the text only manages to make problematic" (p. 144).

Three-dimensional Narrative Inquiry Space

Clandinin and Connelly (2000) suggest that thinking about a three-dimensional narrative inquiry space is like imagining a dynamic, living space - stretching and changing. Focusing on such a space as interaction, continuity, and situation highlights the importance of storytelling the narrative quality of experience through time and cultural expression. By emphasizing these relational orientations, reflective analysis through the actions of narrative generated new forms of knowledge as a component of the study. In overlapping aboriginal people's perspectives with my Anglo-Irish perspective, a shared methodological paradigm emerged that placed in context the experience of living with diabetes from a new vantage point. It raised attention to the overlooked epistemological and ontological implications of aboriginal ways of knowing and being for nursing science. For they are ways by which to recognize how such implications can influence the development of knowledge, practice, and research in the professional discipline of nursing, as well as for the social sciences and humanities.

Interaction – Personal and Social

In pursuing an understanding of indigenous world cultures, I have come to appreciate that oral narratives are formulated through representation, connection, story, and art. I have retrieved from such sources valuable interactions that highlight understanding and wisdom through personal and social experiences and opportunities for immediate interpretation of what is being presented. As a narrative inquirer I discovered through stories a world that was further exposed, where bridges appeared to new interpretations and understandings. As sociologist Plummer (2001) explains:

> … to tell the story of a life may be one of the cores of culture, those fine webs of meaning that help organize our ways of life. These stories…connect the inner world to the outer world, speak to the subjective and the objective, and establish the boundaries of identities…. (p. 395)

I find the idea of identities as *big as life* contributes to an enigmatic quality found in stories. The philosopher, Crites (1971) refers to this as enabling us to share our particular and universal human qualities, our differences, our similarities, our happiness, and our sorrow. He takes this notion further with the idea of transferability, whereby we position ourselves, along with our sensibilities and personae, into the experience as reader of narratives. For instance, Deloria (1990) wrote a book called *Waterlily*, an ethnographic narrative that revealed the interconnectedness in the lives of Dakota people at the beginning of European contact. Her story illuminates the connection between personal and social, exposing the ease with which I am able to recall and recollect my own life stories. Moreover, by remembering stories in the lives of others, narratives become connections between the social, historical, and the personal. Profoundly, it has been recognizing how we get caught up in the *mundane stories* that shape us like *sacred stories* – storied ways of knowing (Clandinin & Connelly, 2000) - that has assisted me to develop the insights necessary to understand complex elements inherent within indigenous world views.

Continuity – Past, Present, and Future

From an Aboriginal Canadian perspective, I see the past and present expressed in stories and art serving as signposts for future progress towards aboriginal self-determination policy and self-government. I have witnessed artistic expression that illuminates dimensions of continuity in aboriginal knowing in this way. For instance, counter-narratives of historical events around the elimination of the *Indian* rationalized as the extinction of an inferior people devoid of culture are prevalent in mainstream society today. These stories help me understand how their form reinforces aboriginal peoples' attempts to understand persisting acts of racism.

Situation – Place

Silko (1996) discusses what was involved in writing short prose pieces and long essays in which "the written words depended upon visual images, or pictures, to fully express what I had to say" (p. 15). I have learned that the importance of situation as place is understood as representation, for example, in the following American Indian landscape revealing that:

> …Pueblo people have always connected certain stories with certain locations; it is these places that give the narratives such resonance over the centuries. The Pueblo people and the land and the stories are inseparable…a written word as a picture of the spoken word. (p. 14)

Her Native American voice speaks of story and art as a way of life, a freedom to live a truth, and a means from which wounds from past inflicted degradations heal. Narrative inquiry as a relational methodology preserves story, art, and healing as elements of each other found embedded in aboriginal people's family and community life.

A New Adoption Story

It is with deep respect for enduring and delicate human relationships that I have included the following narrative to illuminate a personal form of living, in which interpretations of family and community relations have become clearer through a new adoption story. And it is reflective, further, of an experience that is creating between a mother and daughter, something that is primordial in its understanding of social relatedness as evolutionary and timeless. For in the first few days of being with our daughter, we were interpreting the secrets of life in new ways.

The trip began after months of waiting. With the assistance of local and international agencies, our decision to adopt a child from China was coming to pass. During the Chinese Moon Festival, my husband and I traveled to the city of Wuhan to receive our daughter, located in Hubei Province of central China. She was a courageous little girl, who when placed in my arms cried honest and frightened tears. For as I held her warm, soft body close to mine, the wheels of attachment were spinning. And I could feel them turning in the presence of three people who had begun to be gently entwined.

Dear Hui-Jian: It is our first night with you. So much has happened! I have not had a chance to write. Yesterday after we arrived in the big city we quickly checked into our hotel. With all the families we boarded a bus and hurried to the Registration Office in a hotel nearby. Everyone was so excited! Your Papa had tears in his eyes. We waited in a large room with leather sofas and windows letting in natural light. Women began bringing the children to us one by one. We waited and waited. It seemed like an eternity, because you were the last little girl to arrive. A woman with a beautiful smile placed you in my arms. A man carefully placed a bag of your belongings over my arm. Everybody was smiling! It was in a way I had never seen before. We began to thank these people, and there was great kindness in their eyes. Love Mama.

Our experiences included being cradled by the support and relations of nine families. As a small community who shared a common purpose, we all felt like we had the whole world in our hands. Feelings of timeless uncertainty and happiness filled the humid air. Cameras and camcorders tried to capture and freeze the happenings in space and time. Our child was two years old and beautiful. The young woman, having placed Hui-Jian so securely in my arms, warmly spoke the word *Mama* to her. It was in a way that affirmed my own belief I was her mother. And the value of that moment went on to affirm my own belief that I had always been destined to be her mother. For I know the value of that moment will remain with me forever, an experience that will hold such significance for Hui-Jian and me, forever.

We were given gifts, including a photo album filled with images of our daughter's life. There was tremendous generosity and care extended toward us, and our thoughts became indebted to a foster family and biological parentage who we knew only in our hearts. As I left holding Hui-Jian in my arms, it felt surreal to be walking toward a bus parked beside an urban sidewalk in China. Somehow, as if lifted above the hard, trodden ground, humanity had taken notice of us. It was just a sense, but it was if for a fleeting moment the people around us were witnessing a new family arrive into a cultural world of their own for the first time.

Dear Hui-Jian: That evening, you cried. I held you tight in my arms. I consoled you and patted your back. We walked you back and forth across the room. We waited for your eyes to close. We watched your body sleep. We woke up with you in the morning. You were surprised to see us. Everything was new, and everything had changed. You are so beautiful! You were thirsty so we gave you lots to drink. And after breakfast we made our way back to the Registration Office. A formal interview with the government people took place and we signed many forms. Dad and I had our fingerprints taken, and you gave them your footprint. They gave us a special gift for you, symbolizing that you will have a life of happiness and good fortune. They told us you are a very lucky girl. They know your Dad and I will love you very much, and will provide you with many opportunities in life. We presented them with three silk scarves, illustrating the art of ravens and bears through aboriginal designs. They symbolized the strength and fragility that exist in our relationships, and in our lives. One was for your foster mother, one for your nanny, and the other for the director of the social welfare institute. We also gave them boxes filled with toys from our university community, who had wanted to give gifts to the children remaining behind. Everyone was very happy! Love Mama.

The days that followed were both challenging and exhilarating. We were discovering through adoption the guidance that originates from genuine and trusting relational moments with others. And for my husband and me, they were moments that connected our inner world, further, to our child, as well as to each other. I still think about the children who were adopted that day in late September. I think about how they all had been raised in foster families, a practice not always encountered in inter-country adoptions. I think about the relational significance this will have for each child in years to come. I think about how I had soothed the cries in Chinese that Hui-Jian spoke for her foster mother those first few nights, numbed by the emotional pain that denied her body to eat or drink. It made me reach out to her, sink into the profoundness of tender need, and revel in the gift of life that she was for us. It will never cease to amaze me how quickly Hui-Jian responded to our consoling with immediate acts of bonding and attachment. And it was this pouring out of our emotions for each other that encouraged the interconnections, familiar to family and community relations, to take hold and grow.

Dear Hui-Jian: This evening we went to a local 'Hot Pot' restaurant with a few families. It was an incredible meal and you loved it. The place was bustling and packed with people. They brought a large pot of boiling water and set it on a burner that was lower than the center of the table. Dad went to collect plates of meat, fish, and vegetables. It cooked very quickly in the boiling water. Your appetite was voracious and I fed you, almost continuously. We had so much fun cooking the food. You were asleep before we got back. We tucked you in bed between us. You woke up in the middle of the night, crying. I walked you back and forth in my arms again until you fell asleep. We love you so much, Hui-Jian. Love Mama.

Over the next few days elements of our relationship with our daughter were transpiring as if we had, somehow, been together for a much longer time. I continued to be amazed at how receptive Hui-Jian was to our attention and affection. She wanted to be held often, and I could see and feel her take refuge in us. For it made us respond to her with prolonged and attentive awareness. And the everyday occurrences that we take for granted became in China, profound events. I marveled at how going for meals, being a guided tourist, and figuring out what to do in our hotel room had been effortlessly transformed into significant and meaningful events. As Hui-Jian spoke to us in Chinese and as we spoke to her in English, we understood each other in all the ways that go beyond the use of words. We were at the center of the universe, understanding the love that was flowing back and forth between us. It was the most precious thing on earth.

Dear Hui-Jian: We just spent a glorious morning at East Lake National Park. Our guide, Joanna, has been telling us about the important people from this area and of Hubei Province. We placed you in the umbrella stroller and walked all around the park. We cruised along the walkways that traversed over the lake water and growing lotus. You fed the brilliant orange goldfish and played with Dad on the climbing bars. I took a lot of pictures of you! When we arrived at the hotel we went to a Korean restaurant with two other families. You loved it! We sat you in a chair that was high and close to the table. You became so active! You showed us how you could drink from a glass, place noodles on a spoon, and use a fork. You did all this by yourself! The next morning we went back to the Registration Office one last time. We formally received your passport and adoption certificate. We were also filmed on Chinese television! Then, we packed up our suitcases and traveled to Beijing. You were so rambunctious at the airport, running around and laughing. We saw the happy little girl inside you, and it relieved our hearts to know you were so full of life. And as for your first airplane ride, you were so tired that you slept. And it gave us the pleasure of looking at your sleeping face, as if you had been touched by an angel. Love Mama

As I consider and reflect on the experience of being with a newly adopted child, it is not easy to comprehend everything that is going on. We are in the middle of something wonderful, where days are soaked up and time is stolen at night to revisit the pictures that have been created in our minds. During our last week in China, we did not just visit the Summer Palace, the Great Wall, and Tiananmen Square (Gate of Heavenly Peace). And we did not just experience the Beijing Zoo, Pearl Market, Silk Alley, or the dinners we shared with the children and their new families. We were seeing the world through new eyes – the loving, innocent eyes of our daughter child. Madeleine Hui-Jian was already sitting on the tail of a dragon – a view of the world that was unfolding with fury and fire before her. Such were the moments that marked the joy that had entered our lives, now enriched by a little girl from China. For it left us with a deep sense of awe and amazement at how we had actually arrived at the crossroads we were living. And associated with our uncertainty was a knowing that we had been declared a family, which had been in the making with the efforts of many people in different communities many moons ago.

I now turn to Chapter Two, "Discovering the Literature", which includes a descriptive analysis of the fields of aboriginal diabetes knowledge that guides the involvement of health professionals in aboriginal diabetes programs of care. I conclude the chapter by linking the review with conversation focused on the importance of considering research that embodies significant cultural meanings and sociocultural aspects as vital to the exploration of diabetes. It is hoped that this inquiry accomplishes just that - a way to consider research in context and to name those contexts.

CHAPTER TWO[1]

Discovering the Literature

Promoting culturally competent care associated with diabetes is increasingly viewed as an important nursing role (Canadian Nurses Association [CNA], 2004), which requires a focus on geographical, linguistic, educational, and social differences of aboriginal populations and communities. The CNA Position Statement on Promoting Culturally Competent Care (2004) views this key concept as the application of knowledge, skill, attitudes and personal attributes required by nurses to provide appropriate care and services in relation to cultural characteristics of their clients. And it includes valuing diversity, knowing about cultural mores and traditions of aboriginal populations being served, and being sensitive to these while caring for the aboriginal person.

Canadian nurses define culture broadly, referring to shared patterns of learned behaviors and values that are transmitted over time, and that distinguish the members of one group from another (Dreher & MacNaughton, 2002). In this broad sense, culture can include: ethnicity, language, religion and spiritual beliefs, gender, socioeconomic status, age, sexual orientation, geographic origin, group history, education, upbringing and life experiences (Canadian Mental Health Association, 2002). It is important for nurses to provide culturally competent care to aboriginal peoples. Nurses not only have a duty to provide ethical care to their clients, but in Canada, culture is considered to be one of the 12 key determinants of health. A determinant of health is a "complex set of factors or conditions that determine the level of health of all Canadians" (Health Canada, 2003). Understanding and providing culturally competent care is believed to make a difference to the health of many cultural groups including Canada's aboriginal population. According to Statistics Canada (2001), aboriginals, primarily North American Indian, Metis and Inuit, have grown to comprise 4.4 percent of the population in 2001 and have higher rates of infant mortality, chronic disease, and suicide than other Canadians (Health Canada, 2003).

---

[1] *A version of this chapter has been published. Barton 2004 Advanced Journal of Nursing. 45:519-526.*

One leading cause of morbidity and mortality in native populations of North America is non-insulin dependent diabetes mellitus (NIDDM) (Benyshek, Martin, & Johnston, 2001). The Pima Indians of Arizona are considered to have the highest rate in the world (Lindsay et al., 2002; Farook et al., 2002). Canada's First Nations are now experiencing prevalence rates of diabetes that are among the highest world-wide (Health Canada, 2000; Young et al., 2000). And among indigenous peoples of the Americas, South Pacific, New Zealand, and Australia, diabetes is emerging as an increasingly important health concern (Anderson, 2000). Nurses have been challenged not only to improve the quality of care aboriginal people receive, but also to advocate for the best practices in developing strong aboriginal communities.

Nursing practice initiatives to address diabetes issues among Canadian aboriginal peoples are influenced by trends in research and social health policy, and evolving perspectives on aboriginal health. Globally, there is considerable consensus in the research that prior to 1940, diabetes was close to non-existent in indigenous populations (Hernandez, Antone, & Cornelius, 1999). Following the Second World War a dramatic increase in the prevalence of diabetes occurred, indicating that it is now considered to be an epidemic in progress (Young et al., 2000). Researchers from the United States have collected much of the data, followed by Canadian researchers who began publishing over the past twenty years as rates among First Nations became noticeable. It was observed that significant variability in tribal and regional prevalence was indicative of several trends. They were trends understood as being influenced by profound social, environmental, and lifestyle changes of the past fifty years, which led to the notion of diabetes as an illness of acculturation (Hegele, 2001; Waldrum et al., 1995).

Thus, diabetes became understood as a disease that varied according to local culture and linguistic membership, geographic placement, and the extent of isolated living circumstances. It is a perspective that emphasizes the importance of participating with key aboriginal people and organizations in order to promote culturally competent care associated with diabetes. And it is a direction that recently established Canadian research grant agencies are in the process of shaping in order that an aboriginal diabetes research agenda will be of value to aboriginal peoples and communities across Canada (Wilson, 2003).

Focusing the Review

The purpose of the review was to satisfy my interest in discovering the diabetes literature related to aboriginal peoples as a theoretical backdrop linked to the development of my inquiry. Initially, it took the form of an extensive search of empirical literature on diabetes, as well as lay literature associated with the aboriginal experience of diabetes. Throughout the duration of the inquiry I read, extensively, this literature. Later as method, along with selected readings of critical social theory, postcolonial studies, the relational literature, and indigenous writings, I focused my attention on an analysis of research studies published between 1995 and 2004 on diabetes and Canadian Aboriginal peoples. I identified particular studies that resonated with me in relation to guidelines for indigenous diabetes research that have been given priority on global agendas by the Canadian Institutes of Health Research (CIHR) and Social Sciences and Humanities Research Council (SSHRC). These recommendations include: the creation of strong research partnerships with indigenous communities, including collaborative initiatives with community organizations; support for research that respects indigenous peoples' traditions of thought and experience developed among and in partnership with indigenous nations in Canada and globally; and strategic investment in the research capacity of indigenous and non-indigenous researchers interested in a career of diabetes research.

In terms of discovering a particular area of aboriginal diabetes literature, I focused on 14 studies as major contributions to the fields of diabetes knowledge and the importance of culture. The research revealed to me not only an agency directed toward the establishment of a new paradigm of cultural research by and with aboriginal people and communities, but an ethical duty to consider what culture-specific knowledge had been identified that could have implications for nursing, especially advanced nursing practice research.

Considering the Empirical Context

Increasing awareness of high rates of diabetes among North American native populations has led scholars to articulate a health promotion and illness prevention mandate. It is considered as a way to challenge environmental, social, and lifestyle factors that influence diabetes health, including increased fat intake, reduced physical activity, and an inherited susceptible genotype (Hegele et al., 1999; Lieberman, 2003;

Schulz, 1999). The Canadian Nurses Association (2000) statement on advanced nursing practice roles describes the leadership role of advanced nursing practice as one of promoting high quality recipient care by guiding the activities of a person or group. It is through guiding others and developing innovative approaches to clinical practice that the nursing profession may advance. Changing conceptualizations of research and research approaches, as well as rising diabetes rates (Health Canada, 2000), have contributed to the renewed interest among policy-makers and health professionals in promoting culturally competent care associated with diabetes and aboriginal peoples.

There has been a shift from research understood and organized in relation to aboriginal peoples as intriguing or pertinent research objects to aboriginal peoples who are increasingly seen as researchers and research partners. A cultural approach to health places greater emphasis on conducting research within aboriginal knowledge traditions using aboriginal methodologies, as well as methodologies drawn from experience with non-aboriginal intellectual traditions (Smith, 1999). The intent is to provide an equal partner approach to achieving health. In addition, concern for promoting culturally competent care rooted in social and political structures is based on a critical social theory perspective directed at developing knowledge that addresses oppressive sociopolitical conditions, which limit the health potential of all people (Mill, Allen, & Morrow, 2001). The inclusion of different aboriginal cultural structures to such conditions adds further complexity.

Diabetes is a long-term condition that may lead to medical complications and disability, including kidney disease, heart and circulatory disease, blindness, amputations, nervous system disease, birth defects among infants born to diabetic mothers, and premature death (Valer, 2000). In Canada, prevalence rates range from the lowest in the Northwest Territory and the Yukon Territory in the north to some of the highest rates in Ontario (Maberley, King, & Cruess, 2000). In the United States, prevalence rates among Native Americans and Alaskan Natives have increased 0.2% in the under 20 years of age group and 22.8% in the 65 years and older age group (Burrows & Geiss, 2000). In North America over the last decade, diabetes among Native populations has increased two to five times that of the general North American population, depending upon region.

Also, given the link between maternal diabetes and the development of non-insulin-dependent diabetes mellitus (NIDDM) in biological children, the high risk of perpetuating a cycle of diabetes has cultural implications for nursing practice, education, and research (Dabelea et al., 2000). The prevalence of gestational diabetes among James Bay Cree women in Canada is twice that among women in the general North American population, and the second highest reported in an indigenous population worldwide (Rodrigues, Robinson, & Gray-Donald, 1999). Women who have had gestational diabetes are at high-risk for developing NIDDM and children born to these women are at high-risk of becoming diabetic themselves (Dyck, et al, 2002). A study of the Pima Indians in Arizona, for example, indicated that up to 15% of pregnancies were complicated by diabetes (Dabelea, Knowler, & Pettitt, 2000).

In addition, the American Diabetes Association (2002) reveals a disturbing picture that is emerging in North America regarding recent reports of diabetes in children and adolescents. Data from population-based studies among Pima Indian children from 1992-1996 and from aboriginal children in Manitoba in 1997, as well as data from clinic-based studies among all American Indians during 1996 and from aboriginal children in Australia, reveal NIDDM is occurring in this age group (American Diabetes Association, 2000).

7

The need to understand diabetes and aboriginal peoples has been recognized in Canada. Empirical evidence brings together important developments in the understanding of diabetes as a progressing epidemic in North America and a major health concern worldwide. As a result of past research with the Pima Indians, cultural transitions from traditional to modern ways of living associated with environmental changes, along with a genetic susceptibility, are implicated in the development of NIDDM in indigenous populations (Gittelsohn et al., 1998). Obesity, fasting blood glucose, and insulin concentrations are all important risk factor determinants for the development of diabetes in studies with the Pima Indians of Arizona. Studies investigating the mechanism through which exercise may prevent NIDDM have begun to focus on indigenous populations, many of whom have demonstrated an increase in insulin resistance. To date the lack of exercise remains an important risk factor of NIDDM (Kriska et al., 2001). It is postulated that hyperinsulinemia, insulin resistance, and ultimately glucose intolerance, particularly in those who are obese, result from a practice of physically inactive lifestyles (Stoddart et al., 2002). These findings are important for several reasons. First, diabetes is complex and the variation in high rates among different indigenous groups requires more research. Second, as research continues to unravel the epidemiological features of diabetes, concerns related to the provision of diabetes programs of care that do not benefit indigenous people are disconcerting. Third, much of the empirical evidence is replete with examples of the limited effectiveness of particular diabetes approaches adapted to meet the needs of different indigenous groups in North America (Boston et al., 1997).

In response to these issues, there have been more calls for the implementation of effective community-based screening and primary prevention programs from health professionals worldwide (Griffin et al., 2000; Meltzer et al., 1998). This information is desired in order to form a basis for determining how the health of aboriginal people living with diabetes in Canada compares with the health of indigenous peoples living with diabetes in other countries. It is thought that such comparative information will increase our understanding of how social, political, and cultural contexts influence aboriginal healing and wellbeing.

Approaching the Analytical Review

During the initial phase of the inquiry, I retrieved and reviewed approximately 130 research articles published in peer-reviewed journals between 1995 and 2004 that addressed diabetes and Canadian Aboriginal peoples. I used CINAHL, MEDLINE, and Alternative Health Watch databases and did a manual search of key journals for the years 1998 to 2004, including *Social Sciences & Medicine; Culture, Medicine & Psychiatry;* and *Chronic Diseases of Canada.* Reference lists were examined for additional empirical articles related to diabetes and aboriginal peoples. To ensure credibility of the research retrieved, I included only studies that employed acceptable research designs. Further into the inquiry, I selected for analytical review articles that reported a research study using a Canadian sample, included a measure of aboriginal ancestry, and addressed knowledge of diabetes from a cultural perspective. In order for the diabetes knowledge to be considered cultural, it needed to focus on understanding, preventing, or managing diabetes based on aboriginal perspectives or by evaluating intervention programs. I selected only English-language publications. I excluded studies in which the primary focus was descriptive of the epidemiological, cultural, or biological explanations for understanding diabetes, as well as explorative of the risk factors and determinants of the condition. I also excluded chapters of books, government documents not accessible through computerized databases, and studies that consisted of descriptions of programs for aboriginal people without a research component.

My analytical review resulted in 14 articles that met the criteria. The intent was to consider what culture-specific knowledge had implications for my inquiry, and for advanced nursing practice research, generally. By proceeding in this manner, I considered it useful to identify within the articles areas of culture-specific knowledge that had been addressed, as well as areas that were evident as gaps. No attempt was made to present an integrated summary of the findings due to the varied foci of the studies.

Identifying Aboriginal Ancestry

With the extent of literature on diabetes and Canadian Aboriginal peoples crossing disciplinary boundaries such as biomedical, nursing, and health sciences publications, with an emphasis on the last decade, it is important to consider the nomenclature that has been used to identify aboriginal ancestry. The terms *aboriginal* and *non-aboriginal* are used provisionally in this dissertation, with a clear understanding that they do not accurately reflect the differences among the people and communities they are used to represent. I discovered in the context of aboriginal diabetes research in Canada that the term *aboriginal* refers to the indigenous inhabitants of Canada, which includes First Nations, Metis, and Inuit peoples. Specifically, the term First Nations replaces the term Indian, and Inuit replaces the term Eskimo. The term Indian and Eskimo, however, continue to be used in federal legislation and policy (for example, the Indian Act), and in reports and data generated by the Department of Indian Affairs and Northern Development (DIAND) (for example, status Indian or registered Indian). *Status* or *registered* Indian refers to people who are registered by DIAND as members of a First Nations under the terms of the Indian Act. When distinctions between aboriginal groups are needed, specific nomenclature is used (Royal Commission on Aboriginal Peoples, 1997). I discovered in my analytical review of the 14 studies that First Nations peoples were represented in all the samples. Of particular importance is the understanding that there is no one *aboriginal* identity, just as there is no one *non-aboriginal* identity. Thus, the following conversation framing the analytical review relates to Canada's First Nations.

Analyzing Selected Literature

Of the 14 articles, all but two determined the effectiveness of an intervention program. The remaining two studies (Boston et al., 1997; Travers, 1995) focused on understanding different aspects associated with aboriginal perspectives, of which one addressed the aboriginal meaning of diabetes and the other sociocultural origins of diabetes. Twelve studies explored aboriginal approaches to learning as a result of screening initiatives related to evaluating community-based diabetes programs.

The first study (Boston et al., 1997) addressed the *meaning of diabetes* and utilized participatory action research to understand the meanings that a group of aboriginal people attributed to the rising incidence of diabetes. Researchers discovered that through collaborative inquiry, James Bay Cree understanding of diabetes attributed cause to colonial influences and to a prevalent decrease in bush living. Cree knowledge and experience of diabetes were viewed as fundamental to any intervention for prevention.

In the second study (Garro, 1995), interviews were held with persons diagnosed with diabetes in an Anishinaabe community in Manitoba. The researcher found that the research methods, which emphasized oral discourse, revealed the ways people account for their own case of diabetes, the increase in diabetes generally, and how diabetes is a result of personal dietary choices as well as environmental and social change.

The third study (Travers, 1995), which addressed *sociocultural origins of diabetes*, utilized qualitative and participatory research strategies among the Cape Breton Mi'Kmaq. An understanding of these sociocultural origins related to policy, the market economy, and healthcare. A better understanding of these origins was viewed as being able to facilitate the development of policies and practices that are culturally relevant to the prevention and management of diabetes in aboriginal communities.

In the group of 12 studies addressing *approaches to learning about diabetes*, five focused on aspects within a spiritual, holistic, experiential, or transformational context. The fourth study (Daniel & Green, 1995) focused on a population approach in order to undertake a high-risk screening initiative in three communities in the central Okanagan region of British Columbia. Researchers identified people with undiagnosed diabetes, who provided baseline data for evaluating the effectiveness of an intervention program. The baseline data included diagnostic assessments as well as physiological, anthropometric, psychosocial, and behavioral risk factor screening activities.

The fifth study (Daniel et al., 1999) focused on the effectiveness of community-directed diabetes prevention and management in a rural aboriginal population in British Columbia. Combining qualitative and quantitative information, the sixth study (Gittelsohn et al., 1996) highlights the use of culturally appropriate, community-based diabetes prevention intervention strategies. These researchers developed a model for use in evaluation research, which assisted in the formulation of diabetes interventions in an Ojibwa Cree community in northern Ontario.

The seventh study (Robinson et al., 1995) was a prospective cohort study conducted to assess weight, blood sugar, and activity levels among eastern James Bay Cree, who were experiencing diabetes after a three month return to the hunting and trapping lifestyle. The eighth study (Hanley et al., 1995) described the background, methods, and lessons learned in the development and implementation of a prevalence screening and risk factor survey carried out in a remote northwestern Ontario community. The amicable relationship with the community, the high participation rate, and the high quality and broad scope of the information collected were seen as making the Sandy Lake Health and Diabetes Project successful.

The ninth study (McComber et al., 1996) described how the Kahnawake Schools Diabetes Prevention Project utilized community participation towards the goal of preventing the onset of diabetes in future generations of their people by focusing on developing healthy eating habits and increasing the amount of daily physical activity in their community. While in the same project, the tenth study (Macaulay et al., 1997) described how a variety of intervention models were used to develop the program, including intervention and evaluation components.

In the group of studies that also focused on *approaches to learning about diabetes*, diabetes was understood as a gateway to health promotion that led to a high degree of community support, as well as increased awareness about community-based research projects. In the eleventh study, Herbert (1996) described how the Haida Gwaii Diabetes

Project contributed to the empowerment of the community, while the twelfth study by King-Hooper et al. (1995) described the Nuu-chah-nulth experience of participating in a community-based diabetes education program.

In the thirteenth study, Morrison and Dooley (1996) described the role of the Sioux Lookout Diabetes Program in the prevention and management of diabetes in the northwestern region of Ontario. Finally, in the fourteenth study involving pregnant mothers in Saskatoon (Dyck & Cassidy, 1995), researchers linked the importance of physical activity to the reduction in the incidence of gestational diabetes.

Revealing Areas of Culture-Specific Knowledge and Gaps

These studies served to remind me of an attempt to move away from colonial research approaches that tend to be secular, fragmented, and objective, with an aim to discover definitive truth. Ermine (1995) explains that "those who seek to understand the reality of existence and harmony with the environment by turning inward have a different, incorporeal knowledge paradigm that might be termed [indigenous spiritualism]" (p. 103). The desire to understand aboriginal perspectives is not easy to undertake within research. Couture (1991b) reveals the significance of spirituality as being at the center of an indigenous perspective by explaining "the spiritual as belonging to the world" (p. 60). Thus, indigenous perspectives of spirituality require recognition and respect if aboriginal people are to participate in research, and if aboriginal perspectives are to be incorporated into the research process.

These articles also served to remind me of the lack of literature focused on preventing and managing diabetes that incorporates an understanding of indigenous perspectives related to diabetes, and its social influences on communities. Existing studies just scrape the surface of knowledge that is reflective of aboriginal ways of interpreting the perceived world and simultaneously being part of, or one with it. In other words, there is much work to be done on conceptualizing indigenous non-dualistic thinking from colonial dualistic thinking.

Indigenous perspectives are unknown, relatively, to colonial systems of research. And theoretical exploration of indigenous culture and differences by researchers is limited in terms of understanding contextual orientations. Ermine (1995) explains the contextual orientation of an indigenous spiritual perspective as "the inner space, that universe of being within each person that is synonymous with the soul, the spirit, the self, or the being. [It is that] priceless core [existing] within each of us" (p. 103). Couture (1991a) explains the cultural orientation of indigenous theoretical exploration as:

> Traditional [indigenous] holism and personalism as a culturally shaped human process of being/becoming, is rooted in a relationship with Father Sky, the cosmos, and with Mother Earth, the land ... This relationship ... [is] marked by a trust and a respect which stems from a direct and sustained experience of the oneness of all reality, of the livingness of the land. (p. 207)

Couture (1991b) explains further:

> Non-dualistic thinking develops a physical image of the spiritual. The thoughts of the "world" are as creatures, and processes of growth and becoming, and not as abstract concepts and explanations. [Indigenous] awareness and perception is of the spiritual as belonging to this world, and not to some beyond. (p. 60)

If indigenous perspectives are to advance understanding of new orientations of diabetes within empirical research, they need to be differentiated from the effects of non-indigenous perspectives. Cajete (1994), for example, explains the notion of interconnectedness as a sociocultural origin in relation to an indigenous perspective. He states that for "[indigenous] people, this primary context of relationship and meaning is found in the natural environment. In a sense, all traditional [indigenous knowledge] can be called environmental [knowledge] because it touches on the spiritual ecology of a place" (p. 193). Thus, a healing path into what indigenous participants know and want to know is about "uncovering the [indigenous] story" (Couture, 2000, p. 157) or uncovering, as Couture further explains, "some of the underlying realities and processes that mold the topography of the traditional, [indigenous] mind" (157).

Each indigenous research participant embodies the orientations and perceptions that will influence greatly needed positive diabetes experiences and practices. Battiste (1998) states that like education, research is needed that:

> ...draws from the ecological context of the people, their social and cultural frames of reference, embodying their philosophical foundations of spiritual interconnected realities, and builds on the enriched experience and gifts of their people and their current needs for [healing and wellbeing]. (p. 21)

Thus, if the findings of research studies are to be credible and relevant to indigenous peoples, experimentation with research approaches based on forms of shared inquiries, which incorporate elements of holistic, interdisciplinary, or community-based designs, requires exploration.

The researchers who carried out the 14 studies I analytically reviewed recognized that evidence of positive experiences and practices in their findings were supported by an association between diabetes and indigenous perspectives, which provided a starting point for beginning to explore, theoretically, indigenous culture as different. They also appreciated the necessity to interpret their findings in relation to information associated with local customs, perceptions, and definitions of diabetes as essential. In addition, they viewed culture-specific knowledge as increasing the usefulness of local diabetes research conducted by the health professions, especially when it is guided by aboriginal people themselves.

An emphasis on the complex interplay between socioeconomic and political factors, including broader historical processes and local circumstances, with measurable positive health practices displayed by the recipients of diabetes programs of care, was implicit in the studies. Those influences, however, needed to be explored, theoretically, in order to reveal, explicitly, what culture-specific knowledge was being understood in the discussions of the research. New approaches within shared inquiries are dependent on researchers asking questions related to designing research in light of a willingness to build the perspectives and experiences of indigenous peoples into the research process. McClure et al. (1992) reveal in an extensive literature review of current policy issues concerning indigenous populations worldwide that indigenous people's new sense of empowerment is contributing to changes taking place in the areas of health, community development, and community management. Thus, shared inquiries based on co-participatory approaches that result in the empowerment of participants taking ownership of the research process will have a better chance of generating culture-specific knowledge, as well as providing direction for continuing research with indigenous peoples.

I now link this review with conversations that focus on how I considered culture-specific knowledge as having relevance for my narrative inquiry. And I consider how aboriginal culture-specific knowledge may be shown to embody significant meanings and sociocultural origins related to context. It not only assisted me to intellectualize the different ways my inquiry could consider research in context, but also to name those contexts. As examples, these conversations focus on oral narratives of story, connection, and art; working on multiplicity; and the notion of coherence.

Oral Narratives of Story, Connection, and Art

Carter (1993) has been instrumental to me in distinguishing between narration and story by revealing story as a special kind of narrative. What has become clearer to understand is the difference between what story is and story as a mode of knowing, which points to the narrative quality of our lives where personal stories and researcher stories can be conceived as important sources of knowledge. Given that we learn through storytelling, deeply rooted in cultural life is the inescapable conclusion that life arrives at our doorstep through stories, whether briefly or in detail. Thus, I have come to know story as a special kind of narrative that is characterized by "events, characters, and settings arranged in a temporal sequence implying both causality and significance" (Carter, 1993, p.6).

Locating imagination within aboriginal epistemology has helped illustrate to me how representation, connection, storytelling, and art become expressions formulating the creation of oral narratives. From a First Nations perspective, I reflect on imagination in art based on aboriginal epistemology as a way of working through conflict, playing a role similar to autobiography. The effect of art in the dismantling of a colonial stereotype is powerful, both for the artist, and in a political sense for a *lived* society. Thus, there is a strong connection between art as a creative process and the healing of self. In terms of a deeper connection, I understand, better, the philosophies of wellbeing in First Nations through storytelling, whereby ways of knowing, being, and doing are interwoven with the universe and everything in it.

Working with Multiplicity

The nature of knowledge and its claims concerning the centrality of story in thinking is an important one for me as a narrative inquirer. Although a story can be taken apart in terms of themes, characters, and incidents, as a whole it exemplifies "a distinctive mode of explanation characterized by an intrinsic multiplicity of meanings" (Carter, 1993, p. 6). As I sought an experience of research whereby inquiry into epiphanies, ritual, routines, metaphors, and everyday experience created a process of reflexive thinking about multiple ways of knowing, it required me to recognize a depth to experience in which the unknown of the self can surface.

As such, I viewed conversation, discussed as both method and methodology (Denzin & Lincoln 1994), as having ways of locating, making, and revealing meaning. In a First Nations context, I perceived conversation as essential to working with multiplicity in First Nations people's stories. Further, I believed that to establish and sustain trust, especially when researchers exhibit cultural differences, acts of sharing knowledge and meaning represented in the use of conversation, required development. I discovered that it was through the open-ended complexity of such discourse that conversation continued to be shared and valued. In exploring First Nations people's stories of diabetes, the research gave voice to First Nations people's identities in narrative form, which can be expressed in multiple art forms such as published articles and books, or performances of drama and film. Thus, central and enduring to narrative inquiry is encouragement for researchers and participants together to trust in life, to listen to their teachings and the stories they tell, and to the stories told to them by whom they teach (Coles 1989).

The Notion of Coherence

As I considered the question of how to conduct research in a holistic way, I attended to Carr (1986) who proposes the notion of a whole life. He suggests that thoughts regarding individual human existence and character require an examination of personal identity in terms of what is referred to as *unity of life* or *coherence of a life-story*. I view the notion of unity of life as a valuable vantage point that offers a perspective of one's life to understand coherence and meaning as parts hanging together, which Carr views as an achievement we struggle toward. To illustrate, consider an autobiographer who tells a life story as it is lived but also the biographer who tells the same story as a whole life story after the person is not alive to tell it. Can the notion of temporality be removed from meaning?

I think not. From a First Nations unity perspective, Ron Sebastian, a Northwest Coast Gitskan Wet'suwet'en artist, commissioned by the Prince George Two Rivers Art Gallery in British Columbia, Canada, designed and carved a crest pole for display in front of the new building. The design Sebastian chose for the project represented a confluence of philosophies – a crest pole promoting unity and healing from past colonialist practices.

By carving four figures into the pole - white, black, yellow and red - the pole symbolized the opening up between people and healing of the discord that exists between nationalities. I had the privilege of being present at the pole raising ceremony for this powerful piece of art, which was named *Unity and Diversity*. It is a First Nations contribution destined to remind the world of the necessity to heal the chasms established between peoples and societies unable to share in the wealth of their differences.

I now turn to Chapter Three, “Living Out Relational Methods on an Aboriginal Landscape”, descriptive of the choice of methods involved in the process of making meaning of experience within aboriginal stories of diabetes.

CHAPTER THREE

Living Out Relational Methods on an Aboriginal Landscape

The purpose of my inquiry was to co-participate with four aboriginal people living with diabetes and to co-construct through dialogue and conversation aboriginal stories of diabetes. According to Clandinin and Connelly (2000), there exist within questions of method in narrative inquiry three sets of considerations: theoretical considerations; practical, field text-oriented considerations; and interpretive-analytic considerations. In this chapter, I describe topics inherent in those considerations and discuss how such a framework guided the living out of relational methods on an aboriginal landscape. It was a process that viewed aboriginal storied experiences of diabetes as context and established the rationale for integrating selected life stories from the participants, as well as the researcher, into the thesis. The result not only served to reveal points of symbolic interaction among us, but also served to illuminate acts of interaction that existed between time and method. Thus, as a narrative inquirer deeply cognizant of time, who lived an unfolding process of narrative research, I learned how temporal influences informed the events under inquiry, how purposive sampling was efficaciously enacted, how content and structure of data collection were negotiated, how analysis techniques were reflexively utilized, and how the representation of findings through narrative thinking and hermeneutic phenomenological thought was realized through creative acts of writing (Sandelowski, 1999). I now turn to this process of narrative research.

Theoretical Considerations

Sorting Out a Narrative View of Experience

Theoretically, the main issue for a narrative inquirer is to sort out a narrative view of experience (Clandinin & Connelly, 2000). Instead of beginning the inquiry in theory as formalists do, I began with explorations of the phenomenon of diabetes as experience. Although I expected aspects of my inquiry to have features of hermeneutic phenomenology, kept in the foreground were the four participants' narratives of experience, as well as the researcher's narratives, situated and lived out on *storied landscapes* as my *theoretical methodological frame* (Clandinin & Connelly, 2000).

Within this frame was a view of discovery that located the participants and me in the midst of something where we selected to recognize it as *bits of life* worthy of dialogue and conversation. As we sorted out a narrative view of experience by thinking narratively, we made sense of what was surfacing in our minds. This *surfacing* took the form, for example, of trying to figure out taken-for-granted actions, the complexity of pieces of story (narrative threads) at work between us, the rhythms and cycles of our interactions, and just the mystery of it all. Then, when something surfaced that was significant and expressed narratively, it became "specific stories one [caught] hold of like nuggets" (Clandinin & Connelly, 2000, p. 79).

Knowing that narrative inquiry is aimed at understanding and making meaning of experience, I considered the process of *experiencing the experience.* Such a perspective captured the "richness, nuance, and intricacy of the lived stories and the landscape" of both the participants and the researcher (Clandinin & Connelly, 2000, p. 80). Then, at particular moments in the process of being in the field, writing field texts, writing interim texts, and writing research texts, I had realizations that led to interpretations as I worked in the three-dimensional inquiry space (interaction - personal and social; continuity - past, present, and future; and situation - place).

Revealing Meaning in Dialogue and Conversation

During my last year of doctoral course work, I found literature related to action research (Carson & Sumara, 1997) and ethnography (Bateson, 1994, 2000; Geertz, 1973, 1983, 1988, 1995, 2000), as well as an Indigenous Scholars Conference (University of Alberta) extremely useful in terms of thinking narratively. Such scholastic opportunities enabled me to reflect on the intertwining of new cultural interconnections and sets of relationships. Such reflexivity provided me with insights into the locating, making, and revealing of meaning in dialogue and conversation. These and other writings from the relational literature (Merleau-Ponty, 1962; van den Berg, 1972) assisted me to inquire into the process of making meaning of experience that also considered the complexity of cultural concepts and skills required for thinking narratively. Profoundly, I recognized that the process of making meaning of experience was made relationally through dialogue and conversation – the double helix of the method itself.

I found that the relational aspect of research as a living practice (Sumara & Carson, 1997) expanded my thinking in terms of the conversational tone of my inquiry. They explain:

> …who we imagine ourselves to be as human subjects is always entangled with the work that we do….how thinking about action research in new ways has enlarged our understanding of not only action research but of ourselves….representing new ways to think about educational-action-research practices…. [creating] a location for new inquiries into what constitutes knowledge and its production….[this excavated] space for such work is important. (p. xxxii)

As I thought further about my inquiry with aboriginal participants, the question of how I could set a conversational tone to my research that would open up cultural understanding through the essentiality of dialogue and conversation within the three-dimensional inquiry space became an important issue. Such a theoretical consideration influenced, significantly, the success of my work alongside aboriginal participants throughout the life of the inquiry.

While I propose that conversation can be both methodology (Feldman, 1999) and method (Denzin & Lincoln, 1994), my intention is not to provide evidence that conversation can be used effectively in qualitative inquiry. This has been documented in the literature (Cochran-Smith & Lytle, 1993; Hollingsworth, 1994). Rather, the *nature* of conversation was of central interest to me, which focused on understanding the process of making meaning of experience through conversation. Such a process involved sharing of knowledge, creation of knowledge, and the growth of understanding that transpired in a relational environment - an inquiry into the process of research as a living practice.

My interest in poststructural action research as one form within the action research tradition focused on the interpretation of lived experience that considered simultaneously research and practice as being a reflection of one's life. Drawing on Feldman's (1999) representations of the use of conversation – oral inquiry processes and collaborative conversations - I proposed that conversation as research provided access to knowledge and meaning in hidden territory to stories not yet told. Conversation as research provided a new vision of what knowledge could look like and what personal and professional influence it had. Drawing on Carson's (1986) view of conversation as a hermeneutic activity, my participants and I were provided with new vantage points towards understanding and explaining aboriginal stories of diabetes. As a researcher, it was through my experimentation with conversation as method that helped elicit new cross-cultural understandings of diabetes. It was through my experimentation with conversation as I drew on hermeneutic philosophical perspectives and Aboriginal Native North

American traditions, such as the sacred circle, that the juxtaposition assisted in revealing the location, making, and meaning of cultural meaning. In the process, consideration was given to viewing how dialogue and conversation are essential to narrative inquiry in ways that relationally enabled my participants and me to co-participate and co-construct aboriginal stories of diabetes. Ultimately, in living out relational methods on an aboriginal landscape, conversation became one way of co-composing field texts.

Thinking about Research as a Living Practice

Further to understanding research as a living practice, the words - *unless we see what is understood as applying to us* – provided me with a reference point in terms of connecting an essential dimension of hermeneutic activity - *the hermeneutic circle* - to understanding the unfolding texture of human experience – *the aboriginal sacred circle.* The influence of thinking about research as a living practice assisted me to consider indigenous research as a living rebirth, which moved me in profound ways. I realized that as a narrative inquirer who uses dialogue and conversation as a vehicle for storytelling, I was assisted to think narratively by exploring the complementarity of the hermeneutic circle with the aboriginal sacred circle. Such a consideration required me to view social structure and sacred expression in our lives as being enmeshed and entwined, whereby the discovery of possible connections or non-connections between cultures for co-constructing the aboriginal stories of diabetes were discovered. Thus, the core insights of these old views was that humans are connected to all other forms of life, that we are a part of the whole of things, and that our relationship with nature was our most basic reality.

By considering narrative inquiry within the framework of our humanity, the participants and I were better positioned to hang onto our experiences through meaning questions and dialogue derived from thinking with a story and staying true to the story. Such stories were elicited from a perspective of self that was always re-constructing itself. Such a view of inquiry characterized as a living practice facilitated the excavation of slippery aboriginal and non-aboriginal epistemological spaces for understanding the self, others, and the world differently. Such locations revealed new seedlings of self-growth that resulted in new understandings between the participants and the researcher, which are by nature the rarest of relational understandings associated with making meaning of experience. The results of such an inquiry were understood in terms of, for example, what the participants were able to achieve for their personal development; what the participants and researcher were able to learn about themselves and the relational knowledge between them; what the participants and researcher were able to view as successes within the process and who would or would not lay claim to the successes and tensions made visible; and the particular personal lessons I as the researcher acquired for myself.

What I created within my dissertation work was for the aboriginal participants to experience research as dialogue and conversation that opened up an understanding and moral commitment to the relational nature of such a venture and the potential for discovering a more transparent relationship between participant and researcher. By considering research as a living practice, I viewed the participants and my self better equipped to think reflexively and narratively. Our ability to co-participate and co-construct a narrative about the aboriginal stories of diabetes was enhanced. Thus, I think such spaces had a better chance of revealing the deeper cultural understandings inherent within relational-reflection, relational-learning, and relational-transformation. These considerations were essential to the process of making meaning of experience and to making sense of aboriginal people's experience of living with diabetes through what Clandinin and Connelly (2000) term *stories to live by.*

Practical Field Text-Oriented Considerations

Beginning the Inquiry with Participants

Based on my qualitative research experience in entering the field, I took the view that selecting participants for a narrative inquiry required skill in identifying the characteristics of a good participant, as well as skill in locating the best possible participant. I co-participated with one man and three women of aboriginal ancestry who had been living with a diagnosis of diabetes for approximately ten years or more, and who were doing well living with diabetes. They possessed extensive personal knowledge and exhibited a command of articulating their knowledge. They were also informants who had first-hand, current involvement in the aboriginal cultural landscape. As part of the recruitment method, I approached these four participants with the assistance of two rural physicians whose relationship with them was friendly, long-standing, and trustworthy. I had no prior form of contact with the participants, until they had been recommended to me. The fact that we were able to get to know each other a little through an interview related to another diabetes study was essential to their decision to participate, as I had no prior connection to any of the Bella Coola Valley health facilities or communities.

In terms of recruiting four participants, I realized that this could be considered a problem in terms of applying criteria of substance and rigor in relation to qualitative research and dealing with, for example, guidelines suggested by Morse and Field (1995) to ensure a selection of participants that result in a sample that is *information rich.* In order to be true to a narrative inquiry approach, I decided to make a conscious decision to conduct the inquiry in this way. Due to the relational nature of the methodology and methods, and the depth of interpretive-analytic considerations, this sample was information rich. I realized, however, that the sample size did not allow me to draw on significant examples in order to identify critical incidents that could be generalized to other situations.

Further to successfully locating a good participant who would facilitate the development of a relationship necessary for a narrative inquiry, I found five characteristics identified by Spradley (1979) useful. They included: (1) thorough enculturation as the process of learning a particular culture, (2) current involvement within the cultural landscape, (3) expertise related to assisting the inquirer to perceive tacit cultural knowledge related to an unfamiliar cultural scene, (4) a commitment to devoting adequate time to a series of interspersed conversations, and (5) an analytic perspective as the ability to analyze their own culture from an outsider's point of view that introduces another level of complexity. I found it interesting that according to Spradley (1979), "the most productive relationship occurs between a thoroughly enculturated participant and a thoroughly *un*enculturated" inquirer based on the understanding that it is natural to take "too much for granted because it [is] part of [one's] own cultural knowledge" (p. 50).

I disagree with the need for a thoroughly unenculturated inquirer and would argue that the most productive relationship would evolve with a somewhat enculturated inquirer. Based on the understanding that familiarity with experiences on the Aboriginal

Canadian cultural landscape would make the inquirer better equipped to peer into the underside of the surface landscape, the chance for both participant and researcher together to perceive the underlying construction of social cultural relations is greater. With such sensibility, I was interested in having revealed to me the social, cultural, and institutional narratives that shape us from the reality of culture that is of a world between worlds (Bhabha, 1994; Thomas, 1994). These cultural locations with their edges and boundaries fluid and circular in nature offered new perspectives, interpretations, and insights into a discussion of cultural difference and its relationship with the contemporary aspects of our lives as we lived the inquiry process together. Based on the writings of Torgovnick (1996), hooks (1997), and Heilbrun (1999) and how they write about life stories, they illustrated to me a constructive approach towards recontexualizing cultural perspectives of the past that link to local perspectives of the present. Thus, with the discovery of good participants, the importance of both the duration and frequency of dialogue and conversation, and the authentic quality of the emerging relationship, my participants were empowered to shape, according to their world view, the unfolding nature and focus of the inquiry.

Negotiating Entry into the Field

The field of research is described by Barton, Anderson, and Thommasen (2005) as follows:

> Bella Coola is a rural community of 2250 people on the south-western coast of British Columbia, Canada. According to the 2001 census, 43% of the population of the Bella Coola Valley belong to the Nuxalk Nation, who reside predominantly in and around the Bella Coola township. The valley is part of the traditional territory of the Nuxalk Nation, located 1000 km from Vancouver and 500 km from Williams Lake, the nearest regional centre. The Nuxalk people are a tribe of Salish-speaking Coastal Indians who settled in the Bella Coola Valley, but formerly lived throughout the surrounding British Columbia Central Coast area. The diabetes health services are located in a small, modern hospital and clinic that provide medical care and community health services for the Bella Coola Valley. Bella Coola is serviced by physicians, acute care and community health nurses, a nurse practitioner, as well as allied health professionals. A formal, hospital-based diabetic teaching centre is a day's travel by road, located in Vancouver. (p. 243)

Adherence to an ethical framework of narrative inquiry, following approval by the University of Alberta health ethics review board, commenced with professional and collegial relationships with two physicians. They invited me to conduct my inquiry in

Bella Coola. As family practice physicians, they provided me with an invaluable opportunity to be introduced to eight aboriginal people living with diabetes, as well as to a research environment that contributed to the establishment of trusting and respectful relationships between the participants and me. From those eight people came my participants, George, Emilie, Violet, and Hazel, who exhibited genuine interest, authentic commitment, and unwavering generosity throughout the entire process of the research. Significantly, it became clear to me early in the negotiation of ethical matters how we had all, somehow, already been awakened to the ethics that emerge from narratives of experience as participants and researchers. It made me think about the words of Blaise (1993), that explained how there is a tendency for good ethical practices to come full circle:

> The events in our lives, places we have been and the people we have known, keep coming back. Our life is one long novel and as we work our way through the second half it's a small wonder we never escape those crucial first pages, when the light was set for all time, when the world is an intimate place, and all its inhabitants were known by name. They were all at the dance and they got their hands stamped on the way out. They can wander back without paying, without warning, any time they want. (p. 43)

These thoughts enticed me to think, further, about a context revealing the complexity of relations evolving with narrative inquiry practices (Clandinin & Connelly, 2000). It was a complexity that required an understanding of our interdependence on others within the human condition, in order to recognize the temporal flow and shape of events (Miles & Huberman, 1994). And it was essential that my choice of methods involved in the process of making meaning of experience be based on sound rationale.

I begin by drawing attention to the *Summary of Methods and Information and Consent Letter for Participants* located in Appendix A. Specifically, the information and consent letter explained the research in terms the participants would understand; outlined the promises I intended to keep with respect to ensuring their confidentiality, anonymity (should they so desire), and privacy; their right to have me revise the research texts in response to their feedback; and their right to withdraw from the research at any time. In return, they agreed that I had the right to publish or to present any material that would result from our partnership. The form was signed by the participants prior to the commencement of the inquiry.

Relational Background

While conducting a qualitative diabetes study with the two physicians in Bella Coola in January of 2003 (Barton, Anderson & Thommasen, 2005), prior to the commencement of my doctoral research, I met and interviewed eight aboriginal people living with diabetes who had long-standing relationships with these physicians At the end of each interview, I had the opportunity to explain my future doctoral research and to elicit their interest. Critically, inherent to the ethical challenges that arise at this phase of negotiation between a non-aboriginal researcher and aboriginal participants, is a code of ethics made apparent by Clandinin and Connelly (2000). As a narrative inquirer, research relationships are continually negotiated, with negotiation of entry as a step commenced at the beginning of an inquiry followed by *negotiating purposes* throughout the life of an inquiry. Attention to *working on the relationships* is thus appreciated, making visible the necessity to not only explain ourselves to others in order for us to become clear on the details of the inquiry, but also the opportunity to converse with the participants in ways that shape "what is interesting and possible under the field circumstances" (p. 73).

I discovered such advice to be most useful. Both physicians had recruited these eight participants from the Nuxalk Nation, who also met my criteria of aboriginal people living with diabetes and who might want to tell in-depth stories of their experiences of diabetes. The opportunity to be involved in this preceding research provided me with the means to establish a beginning relationship with potential participants, as well as a guided sense of who to approach by telephone. Several weeks later, one man (George) and one woman (Emilie) agreed to participate in my doctoral research. Another woman was interested, but was unable to commit at that time. Several months later she declined to participate, citing personal and work commitments as opposed to disinterest.

In March of 2003, I returned to Bella Coola for two weeks and began my inquiry with George, followed by Emilie. In June of 2003, I returned to Bella Coola for four weeks, completed the last conversation with each of the first two participants, and secured the agreement of two additional women. Then, I began my inquiry with Violet (the third participant) followed by Hazel (the fourth participant). Due to the extensive amount of information elicited from the retelling of life stories, it was critical that I focused on each participant one at a time, in order to be fully attentive to the intricacies within those stories. By the end of June, all conversations had been completed. Approximately every four months thereafter, I talked with the participants by telephone to update them on the progress of the inquiry and to converse socially. These telephone conversations, as well as a face-to-face visit with each person in September of 2005, were used to elicit feedback on their specific research text that had become a findings chapter within the dissertation. It was during this last formal face-to-face visit that we discussed their decision to identify themselves and their community within the dissertation text. Each participant chose to sign a specific consent form. It indicated that they agreed to have their identity and community revealed within the material that resulted from our partnership, which I had the right to publish or to present in the public domain. Three participants chose to reveal their real names, while one participant chose to reveal a favored name, with the understanding that she was not concerned about her anonymity. This consent form is located in Appendix B.

The four participants made it clear to me throughout their involvement that they all viewed the inquiry as an important opportunity for sharing and learning about the experiences of living with diabetes. They indicated that it was important to them that I was a researcher with extensive nursing experience living and working in rural and remote aboriginal communities, as well as teaching experience in the area of aboriginal health. They also disclosed that they were honored that their stories would be published so that other aboriginal people living with diabetes, as well as health professionals working with them, might benefit from our research partnership.

When I had completed the analysis phase and was well into the formal writing phase of the dissertation work, I was filled with anxiety that they would become frustrated with the length of time taken to complete the final version of writing. At the end of each telephone conversation, however, I was reassured of their continuing deep sense of commitment to the research process, as well as to their ongoing patience with me as the dissertation was being written. They always left me with a reinforced sense of gratitude for the kind of research partnership that had evolved, of which I was continuously grateful.

Collecting the Data

Over a two month period, I collected rich material on the experience of living with diabetes from George, Emilie, Violet, and Hazel, which was embedded in the culturally textured fragments of their life stories. They were life stories not only of themselves, but of those who experienced their lives with them and of those who cared for them. Through narrative inquiry, we attempted to freeze specific moments of personal story. As we engaged in conversation, more stories and the narrative components of those stories were told, sometimes in a circular manner. Within these reconstructed narratives resided the conveyance of meaning, social significance, and purpose - *powerful local stories*.

It caused me to reflect on how this narrative inquiry process closely paralleled the suggestion by Denzin and Lincoln (1998) that in the "fifth moment" of today's reality, narrative terminology will increasingly "define and shape" naturalistic research. And that the "gendered, multiculturally situated researcher, using a variety of collaborative approaches will construct more local, small-scaled theories fitted to specific problems and specific situations" (p. 21-23). I considered how research will be "defined by a series of tensions, contradictions and hesitations which will articulate issues of morals and ethics as central features of any knowledge that claims to speak with an authoritative voice" (Denzin & Lincoln, 1998, p. 31). Thus, in seeking out appropriate methods, narrative inquiry provided me with the guidance by which to address the "ideological, moral, emotional and practical complexities" foundational to issues of ethics (Josselson, 1996), and by which to contemplate "the crisis of representation" (Denzin & Lincoln, 1998):

> We study the other to learn about ourselves, and many of the lessons we have learned have not been pleasant. We seek a new body of ethical directives...The old ethical codes failed to examine research as a morally-engaged project. They never seriously located the researcher within the ruling apparatuses of society. A contextual-consequentialist ethical system will continue to evolve, informed at every point by the feminist, ethnic, and cultural studies sensibilities. (p. 381-382)

The process of collecting data ultimately resulted in the representations of four findings chapters, which were the retelling of George's story, Emilie's story, Violet's story, and Hazel's story. Our developing friendship with each other during the research process, and our conversations about how we made sense of identity in relation to their experiences in the world while living with diabetes, was what I believe drew us to the splinters of their stories. I had the profound experience of being with them in the telling of these stories, which illuminated for me a view into specific *life* stories. They, in turn, had the experience of retelling their stories, a process that brought new reflections, thoughts, and understandings to the forefront of their lives.

Within the co-construction of these narratives, we discovered a sense of resilience entangled with vulnerability. They were human responses made sense of through metaphors of the natural world. And they were consistent with Native North American views, which pointed to the sacredness of the earth as the basis for understanding life. They coincided with what I have read of Chinese traditions, that social cohesiveness is derived from nature. They made me think of how the patterns of the universal life force, *qi*, in Yin and yang, the four seasons, the structure of the landscape, and the order of the stars and planets, have long provided humanity with metaphors for social structure and sacred expression. Discovered within such metaphors of integrated complexity was an intricate balance of recognizable circumstances entwined with uncertainty. I believe it was sensitivity to this balance that opened up in my participants' stories the newness, connection, coherence, and peaceful contemplation associated with an understanding of resilience and vulnerability. Interestingly, metaphorical understandings were always part of my participants' stories, and I would walk away from them with my spirit revivified, gently and quietly.

I also discovered something else. According to Bakan (1996), an important "misgiving" consideration that the narrative inquirer is a part of, is that "narrative research, based on the lives of people made public, converts what is private into public; can violate privacy; and can cause mental, legal, social, and financial hurt and harm… [Hence, it is imperative that narrative inquirers negotiate with their participants]… "a conspiracy of silence" (p. 3). These considerations guided my field relations. I was sensitive to respecting and protecting the privacy of the participants, given that various kinds of harm [physical, emotional, and political] may intrude into the lives of the researched, should their privacy be violated. It was for this reason that I sought an appropriate place for the participants and me to engage in conversations. Dr Thommasen and Dr. Anderson were instrumental in arranging accommodation for me that was used for health professionals working at the Bella Coola Hospital and Medical Clinic. The house was located near the hospital and enabled the participants to associate the research visits with hospital visits, and in ways that concealed their identity until the end of the research process.

An additional consideration surrounding consent, deception, and confidentiality of participants and data has been discussed by Bulmer (1982), who suggests that a code of ethics be negotiated between participant and researcher to guarantee that the "identities, locations of individuals and places are concealed in published results" (p. 225). By the end of the writing phase of the inquiry, however, all four participants declined anonymity.

Shifting from Living Stories to Retelling Stories

I engaged in six audio-taped conversations with each participant that each lasted approximately two hours. Geertz (1973) alludes to the complexity of cultural matters that requires consideration in the transition from field texts to research texts. He poses:

> What the [inquirer] … is in fact faced with … is a multiplicity of complex conceptual structures, many of them superimposed upon or knotted into one another, which are at once strange, irregular, and inexplicit, and which he [and she] must contrive somehow first to grasp and then to render.….[something] foreign, faded, full of ellipses, incoherencies, suspicious emendations, and tendentious commentaries, but written not in conventionalized graphs of sound but in transient examples of shaped behavior. (p. 9 &10)

The transition from field texts to research texts was a difficult one, predominantly as a result of relationships shifting "from the intensity of living stories with participants to retelling stories through research texts" (Clandinin & Connely, 2000, p. 129). In finding ways to negotiate a way through, while continuing to sustain the relationships with my participants as I launched into more construction of meaning within the texts, I reconsidered the moral stance of what it means to study with people and to inquire into their ways of life. The anthropologist Malinowski's (1922) use of the word *grasp* in his statement, "to grasp the [participant's] point of view, his [or her] relation to life, to realize *his* [or her] vision of *his* [or her] world", was a valuable one for me to consider (p. 25). The use of the word *grasp* had an effect on me that led me to inquire into understanding the word *attend.* I think that we must attend to the understanding of something if we are to truly grasp it. Therefore, in considering the writing involved in the doing of practical field texts was to *attend* in a disciplined way to the learning from people living another culture, and who have alternate ways of knowing, doing, and being.

Bateson (1994) has helped me to see the deeper meaning in this word. She writes:

> *To attend* means to be present, sometimes with companionship, sometimes with patience. It means to take care of. Its least common meaning is to give heed to, for this meaning has been preempted by the familiar *pay attention*, which turns a gift into an economic transaction. Yet surely there is a powerful link between presence and care. The willingness to do what needs to be done is rooted in attention to what is. The best care, whether by a parent or a physician or a teacher, is founded in observation or even contemplation. I believe that if we can learn a deeper noticing of the world around us, this will be the basis of effective concern. (p. 109)

The beauty of this deeper understanding of the researcher taking care is that underlying assumptions of continuing "to negotiate relationships, negotiating purposes, negotiating ways to be useful, and negotiating transitions" relate to the narrative inquirer learning a deeper noticing of the world, learning from people, and being taught by people (Clandinin & Connelly, 2000, p.129). Hulme (1983) provides a rich and emotionally complex work of literature about a woman who is part Maori, part European, an artist, and a woman disconnected from her family. Resonating in this grasping narrative is a deep noticing of life. Narrative inquiry should be like that; it assumes that all people do not define or interpret the world of objects, events, and living things in the same way, whether languages differ or not. Thus, the narrative inquirer sets out to learn alternate meanings of things with participants and is open to the associated deeper meanings of these things.

Simultaneously, the narrative inquirer does not stop with field texts consisting of, for example, conversations, storied poems, and other compelling material, but realizes that they must be reconstructed as research texts (Clandinin & Connelly, 2000). By understanding the relationships between people and things and between networks of people and sets of things from the particular to the universal, I attended to and grasped the practical field text-oriented considerations – the negotiating of relational transitions and the reconstructing of field texts into research texts (Clandinin & Connelly, 2000).

Being in the Midst of Cultural Narrative Expressions

The words of the ethnographer Frake (1977) capture the flexibility required by a narrative inquirer being in the midst of cultural narrative expressions:

> Culture is not simply a cognitive map that people acquire, in whole or in part, more or less accurately, and then learn to read. People are not just map-readers; they are map-makers. People are cast out into imperfectly charted, continually shifting seas of everyday life. Mapping them out is a constant process resulting not in an individual cognitive map, but in a whole chart case of rough, improvised, continually revised sketch maps. Culture does not provide a cognitive map, but rather a set of principles for map making and navigation. Different cultures are like different schools of navigation designed to cope with different terrain and seas. (p. 6-7)

It is understandable that narrative inquirers must go beyond what is seen and heard in stories to making cultural inferences about cultural meanings, which need to be authentically verified. Based on the many ways field texts can be composed, the importance of being in the place of stories as an important way of being in the field and eliciting authentic and purposeful stories to reveal narrative truth and narrative relativism takes on greater importance. Composing field texts expresses the relationship of researcher to participant and is an interpretive process (Clandinin & Connelly, 2000). Variations within my field texts included autobiographical writing, journal writing, field notes, conversation, transcripts, documents, photographs, and memory boxes. Personal-family-social-cultural artifacts, as well as life experiences, were sources of field texts. Thus, the importance of composing field texts from narrative inquiry spaces and coming to know culture took on greater importance as a stance that opened up other imaginative possibilities. In terms of how field texts were positioned within the three-dimensional space determined the extent field texts were contextual re-constructions of events. Later, interim research texts were composed from those field texts. In other words, attending to the complexity generated from positioning field texts within spaces of interaction (personal and social), continuity (past, present, and future), and situation (place), as well as physicality (embodiment), had "consequences for the epistemological status of the texts and, ultimately, of the research texts that draw from them" (Clandinin & Connelly, 2000, p. 118).

Creating the Field Texts

In a place called Bella Coola, my journey of inquiry continued with each participant by writing field texts based on my experiences of being in the field and of reflecting on the composition of those field texts. I began by scribbling in a notebook, dictating into a tape recorder, as well as typing descriptive field experience observations into my laptop computer. In my living room I continued my journey by capturing conversations about their stories of the experience of living with diabetes, and of their life stories, which were audio-taped and later transcribed.

I wrote about the ethical experience of being a narrative inquirer. Connelly and Clandinin (1988) describe an ethical framework for implementing narrative inquiry that includes four main principles. First, each phase of the inquiry needs to be negotiated through a partnership characterized by caring, sharing, and friendship. Second, "a collaborative stance between participant and researcher" needs to be created (pp. 269-270). Third, the relationship established between the participants and researcher needs to be reflective of a shared narrative unity. And fourth, the process of "restorying" needs to be made evident (p.11).

Later, with the implementation of this ethical framework in mind and copious pages of field texts, I compiled further field texts and interim research texts that consisted of additional transcriptions of participant conversations, more field notes, previous interim research texts, continuing personal narratives, integrative thoughts and reflections, deeper observations, detailed notes, and additional memos. Significantly, these texts formed the basis of narrative, dialogical, and theoretical writings that led to the shaping of research text possibilities. The resulting research texts were shared with the participants, continuing our relationship and dialogue together over time. Ultimately, their stories formed the core material for my doctoral dissertation, where I considered new knowledge possibilities for understanding diabetes mellitus, aboriginal people, and the process of conducting culturally competent scholarship. Importantly, it is knowledge that has implications for the development of cultural knowledge in the practice of nursing and of allied health professions.

Methods inherent within narrative inquiry are based on the creation of spaces in which multiple voices are honored during relational engagements of authentic exchange, specifically those of the researcher and the researched. Such emphasis on issues of voice, ways to seek partnership, sharing of power, and negotiation throughout the research process requires dialogue. Buber (1970) states "dialogue in relationship…is the central interpersonal and epistemological dynamic of narrative research" (p. 137). During this phase of my inquiry, all four participants knew to indicate when they did not wish to have a particular conversation taped or certain details included. They were, however, all equally forthcoming with their stories. It was later, during the co-construction of research texts, that decisions to exclude personal information were made by the researcher in consultation with the participants, and vice versa.

It was also a process where I kept in the forefront of my mind the words of Widdershoven and Smits (1996), who argue that "narrating ethics" considers:

> …relationships between concrete events and specific characters and places over time, in a descriptive manner, as compared to presenting general rules of a more abstract and prescriptive nature…[and that narratives infused with ethical issues]…contain knowledge about practical situations and …emphasize ambiguity, complexity, doubt and uncertainty. (p. 275, 277)

Thus, narrative inquiry becomes reciprocal and essentially relational, both in theory and practice, whereby the narrative inquirer and participants become entangled in each other's lives, an aspect referred to by Clandinin and Connelly (2000) as *narrative unity*.

Interpretive-Analytic Considerations

Moving Back and Forth Between Field Texts and Research Texts

As I read and reread my field texts, sorted them out, and got closer to them, my interpretive-analytic considerations focused on the richness of the participants' and researcher's intermingling landscapes being lived out as new stories. These new stories contained knowledge, context, and identities embedded within our individual multi-layered existences that had changed over time and caused us to grapple, to some extent, with a new view of the self arising from a coalescing narrative inquiry space.

As a narrative inquirer, I also engaged in the work of constructing a chronicled or summarized account of what was contained within different sets of field texts, narratively coding field texts, and relating different field texts to other field texts (Clandinin & Connelly, 2000). It was, however, the "responses to the questions of meaning and social significance that ultimately [shaped] field texts into research texts" (p. 131). Some questions I had were obvious and surfaced easily, while others were difficult to formulate. As I contemplated this phase of inquiry, I was reminded of the words of Neumann (1997) who reconstructed the stories of her parents as post-holocaust lives. She writes:

> While at one level the paper described how I learned of another's life by listening and by trying to understand, at another level it pointed at what I could never hope to learn of a life apart from my own, no matter how hard I tried. It spoke of the silences that emerge inevitably in every text, that grow in every effort to imagine another's life, that accompany every gesture of empathic imagination. It taught me that the stories I hear of others' lives are composed only partly of text; they are also composed of silences for which no text exist. (p. 91 & 92)

With these notions, I thought about how I might go about synthesizing my own and four participants' life stories, and making explicit how this *telling* in itself is an important, shaping event, for example, for identity and relational processes, and in the understanding of cultural differences. Additionally, I thought about coaxing open spaces for deeper understanding in terms of experiencing together the retelling of each participant's experience living with diabetes, living with a long-term condition, and living in places between illness and wellbeing. Ultimately, I discovered ways to integrate such linkages in the doing of the inquiry that surfaced and shaped the field texts into research texts. This location was between the participant's life stories, my story, our story together, and the unfolding aboriginal ways of knowing within the grand narrative (Clandinin & Connelly, 2000) of aboriginal and non-aboriginal relations. It was also within the grand narrative of research, which was dependent upon rigid mainstream thinking made commonplace. However, contrary to a general application of research was, instead, the reflexivity of new theory and practice (Schon, 1991), whereby tensions emerged that did not separate thinking from doing. As I experimented with an alternate culture of research such as narrative inquiry, the dichotomies of prescribed general applications of research were challenged (Clandinin & Connelly, 2000).

Shaping Field Texts into Research Texts

Another complex aspect of moving from field texts to research texts involved returning to them again and again. As Clandinin and Connelly (2000) emphasize:

> … the search for patterns, narrative threads, tensions, and themes that shape field texts into research texts is created by the writers' experiences as they read and reread field texts and lay them alongside one another in different ways, as they bring stories of their past experiences forward and lay them alongside field texts, and as they read the field texts in the context of other research and theoretical works. (p. 133)

Again, I returned to Neumann's (1997) writing to shed light upon how I prepared to maneuver through this phase of narrative inquiry. As Neumann describes herself, she is "a scholar who seeks, literally, to view the space that exists within and between my subject and my self" (p. 91). Knowingly or unknowingly, I realized that the relational distance between my participants and I vacillated between degrees of relating, connecting, feeling in relation, and feeling connected to ourselves and one another. In Neumann's chapter aptly titled, *Ways Without Words: Learning from Silence and Story in Post-Holocaust Lives,* she addresses this distance in between, how she came to recognize it, and how she sought out ways to know what that distance was about. She reveals herself as someone who has learned how little she can truly know of another person's experience. I view this acknowledgement to be of paramount importance to the process of shaping field texts into research texts because stories are partly text and partly silence, but also go way beyond text and silence.

It is precisely the highly personalized nature of being with people living out human lives and doing research with people that precludes adhering to one way for finding meaning within story. I believe narrative inquiry requires extensive experimentation by the inquirer before tangible analytic-interpretive understandings can be revealed. I also realize that the lived and told story will not be neatly laid out for the interpreting, easily grasped or understood. Interestingly, Neumann's journey with her parents' stories was also a journey to find meaning within her own stories. She writes:

> These fragments and splinters of story – and about story, story emerging from the shell of a story I'd heard long ago – grew and joined, interweaving thought-from-right-now with thought-recalled-from-long-time-ago into thought-I-constructed-for-myself, perhaps not in pure fact, but in mind and in love and in wanting to know who she was, who I imagined she was, wanting to believe I knew her, wanting her image in my life right now. I chased after the ghost, and shells, and splinters of her stories… (Neumann, 1997, p. 95)

From my perspective, the knowledge and understanding Neumann gained along with her parents seemed to affect them all in rich insightful ways. They appeared to go in and out of those living overlapping spaces where the distance between one another seemed briefly nonexistent. Whether in the spoken word, written text, or the silences, through my interpretive-analytic considerations, I, too, got a sense of *having been there* or a feeling suggestive of being transformed in some way. This is hard to put into words, but I was able to see clearly how Neumann was attending to a deeper noticing of the spaces within and between her self and her mother and father. She kept positioning and repositioning her interpretations and analyses so as to learn from them. So she continued to be taught by her mother and father in the context of their post-holocaust lives. Further, she set out to learn alternate meanings of things within their experiences and thus open to the associated deeper meaning of these experiences for them. Their stories revealed the relationship between things of emotional significance and between sets of things from the particular to the universal – the knowledge of how her mother and father made sense of their horrific past experiences. Neumann (1997) writes:

> …how in the void of not-knowing, we nonetheless come to know, how even when we have no interpretation, we nonetheless construct one, gathering wisps of sight and sound that surround us into images that, through the weaving of interpretation, become real for us… (p. 96)

Like Neumann, I tried to grasp not just the map my participants were reading, but tried to grasp how they were making their maps. I felt I understood at times how they were making sense of their continually shifting landscapes of everyday life in a world they had been cast in. Through narrative inquiry, I attempted to explain and interpret how living is shaping their lives and influencing what they are experiencing. Neumann discovered through her parents' stories a world further opened up whereby bridges appeared to new interpretations and understandings. It also opened up bridges that were not known to be there. In other words, to tell a story of a life is also not to tell a story of a life, perhaps to lay hidden those fine webs of meaning about other parts of the story, other parts of a life, a fathomless life. Neumann (1997) shares a beautiful self-discovery revealed in her words:

> What emerged as my story of my mother was less a story composed of the knowing that words can bring than a story constructed from the knowing that unworded feeling creates. (p. 96)

Experimenting with Writing Interim Research Texts

The overall process of analysis and interpretation in the move from field texts to research texts was as far away from a series of steps as can be. Since there was no one approach for transforming field texts into research texts, the experimentation of writing interim research texts "designed to be shared and negotiated with participants" are "situated in the spaces between field texts and final, published research texts" (Clandinin & Connelly, 2000, p. 133). I realized through the experimentation of writing interim research texts there resided the uncovering of action and agency within spaces that provided alternate ways for opening up the intriguing and insightful entangled stories that awaited revelation within the study of experiential phenomenon (Clandinin & Connelly, 2000). As I continued to think about narrative as being in our lives and narrative inquiry as the exploration into lived stories, by laying the researcher's narrative alongside the participants' narratives, a relational embodied nature of experience awaited me like an undiscovered place awaits a traveler. Through persistent questions of method, I discovered within myself ways to write narratively, interpretively, creatively, and sometimes poetically. It was laborious and challenging work, writing and rewriting, and examining explanatory or interpretive statements made in relation to acknowledging all factors that could influence the research findings.

As I began writing the research texts through a process of rigorous reflexivity, I tried to ensure that the voice of the participants was being heard. As I considered them the most important audience, I accepted what they voiced as essential elements that enrich the discourse in the construction of new diabetic knowledge. In trusting and respecting our respective language differences, I gravitated to "literary approaches" and "experimental writing" of participants' voices (Clifford, 1985, p. 3). Such contemplation required "writing vulnerably", and revealed an aboriginal culture of writing, the establishment of equitable relationships between the researcher and participants, and provisions for an alternate way around the relatively traditional and impersonal writing style of the academy (Behar, 1996, p.19).

Writing about the aboriginal world of diabetes resulted in listening to the language spoken by the things in their existence, to what things mean in this world, and to the world as our home: our fish pond, our deep sea, the materialization of what it is we perceive. I was deeply inspired to put into language what was being experienced, however incomplete. As I oriented myself to certain existential notions, I sometimes amazed myself about what I was able to put into words. Inspired, I read poetry, such as the words of the poet Rilke, who described how living, memory, time, and reflection are all integrated in the writing of a memorable poem:

> One must have memories … and still it is not yet enough to have memories. One must be able to forget them when they are many and one must have the great patience to wait until they come again. For it is not yet the memories themselves. Not till they have turned to blood within us, to glance and gesture, nameless and no

> longer to be distinguished from ourselves – not till then can it happen that in a most rare hour the first word of a verse arises in their midst and goes forth from them. (In Mood, 1975, p. 94)

Settling on the Research Texts as a Final Version

How I chose to write the findings chapters was a challenging one, but it should be noted that much of the substance of the aboriginal stories of diabetes, along with the participants' own analyses of those events, are framed as particular *diabetes stories* and *life stories*. Initially, for each participant I selected and worked with a set of specific stories from 125 pages of transcription, resulting in 50 pages. It was within these stories that each participant's voice was heard loudly, clearly, respectfully, and honorably. I made grammatical corrections of this material, editing to ensure clarity of meaning and to avoid ethical dilemmas by including stories that do not harm. Then I experimented with those 50 pages by taking the researcher's voice out, putting it back in, and taking it out again.

I finally settled on retaining my voice along with George's voice in the first findings chapter. It is a chapter that not only reveals his diabetic stories and life stories, but reveals our entwined voices reflective of authentic dialogue that is so necessary for implementing relational methods on an aboriginal landscape. Due to considerations related to length of my dissertation, the second, third, and fourth findings chapters are singularly reflective of Emilie's, Violet's, and Hazel's voices, respectively. If length had not been a concern, I would have written each one as I did George's. An interpretive analytic dialogue with the text that is based on each of the participant's narratives follows each participant's set of diabetic stories and life stories. Those were deeply satisfying for me to write.

Each chapter reflects narrative and interpretive analytical writing that has integrated in multiple ways, the existential nature (time, place, body, and relations) of the context of diabetes as experience. In the first findings chapter, George's story is predominantly framed using the existential of time. In the second findings chapter, Emilie's story is predominantly framed using the existential of place. In the third findings chapter, Violet's story is predominantly framed using the existential of body. And in the fourth findings chapter, Hazel's story is predominantly framed using the existential of relationship.

In order to negotiate the various drafts and the final version of the texts pertaining to each of the four participants, I maintained contact with them by telephone, as well as a visit to Bella Coola. As *the experts* on their own stories, their perspectives related to corrections, deletions of sensitive material, additions, and approval, which were carefully processed. With all participants, the receiving of feedback was relatively easy and straightforward, requiring two sessions for each participant. They were accepting and satisfied with the final version of text, with the exception of deleting a few sensitive areas, and offered suggestions that only continued to strengthen its presentation through deeper cultural detail. Significantly, these telephone conversations and a final face-to-face visit became opportunities to make explicit further nuances, ambiguities, and puzzles that surfaced as a result of re-reading and re-working the texts. Understandably, it took until the end of our feedback sessions for all four participants to indicate their desire for non-anonymity by openly publicizing their identity and community. I came to realize how important and dynamic this phase of inquiry was, continuing to collaborate, improvise, and account for meaningful information – the negotiation of research texts as part of negotiating relationship.

Worth mentioning here is how my relationship with each participant was further sustained over time. While being intensely engaged in the reading and writing of the participants' stories, I felt in relationship with them. I think that by reading about themselves, they too felt in relationship with me, even though we did not physically see each other in person. This was validated to me during our telephone conversations, as well as during our final visits in Bella Coola. At the point of sending each participant their respective chapter in April 2005, I included with it a framed picture that I had taken of each person following our conversation session in June 2003, along with bags of jasmine tea. We had sipped a lot of jasmine tea. I felt it not only symbolized our *beneficial* work, but reminded us of *valuable* time spent together. When I met with each person again in August 2005, I gave them a traditional Chinese teacup with matching lid, along with a generous supply of more jasmine tea. These were appropriate and necessary acts of appreciation, and part of living out relational methods on an aboriginal landscape.

Persistent Ethical Considerations

The ethics of doing narrative inquiry involve being in relationship with human beings, which requires accountability and responsibility. As Murphy and Dingwall (2001) suggest, "These obligations are complex and will not be fulfilled through simple adherence to a prescriptive list of requirements" (p. 347). Clearly, the principles of ethical practice are significant in terms of non-maleficence and beneficence; autonomy and self-determination; and justice in understanding concerns of an ethical nature. From these principles, for example, emerge specific ethical principles for the qualitative inquirer such as considering participants first; safeguarding participant's rights, interests, and sensitivities; communicating research intentions; protecting the privacy of participants; not exploiting participants; and making texts available to participants (Beauchamp & Childress, 1994; Brink & Wood, 1994). What and how the researcher thinks, however, about the negotiation of the research relationship throughout the inquiry is, for me, significant in recognizing, understanding, and acting upon ethical concerns that surface.

To this end, I also considered it important to take the necessary steps to ensure my research was ethically sound by also considering "a position of ethical universalism by WHO (World Health Organization) and CIOMS (Council for the International Organizations of Medical Science, 1993) that acknowledges the importance of being knowledgeable about [aboriginal] local cultural traditions and of discussing contentious ethical issues" (Mill & Ogilvie, 2002, p. 809). Such contemplation within my research compelled me to engage in continuing decision making whereby ethical principles were applied "in a manner that is responsive to differences between the researcher and participants in language, culture, and economic status" (p. 807).

As discussed, negotiating the research relationship is a concern that remains throughout the narrative inquiry process. Other ethical considerations, however, relevant to a narrative inquiry that extends beyond the process of obtaining university ethics approval for research require explanation. As concerns throughout the inquiry, they relate to, for example, the ethics of entering the field, composing and sharing research texts, and moving from field to field text to research text. Specifically, I will explain, further, the ethics of doing no harm to my participants; anonymity of both participants and myself as researcher; ownership and relational responsibilities; placing my stories within the research; distinguishing between fact and fiction; attending to the risks, dangers, abuses of narrative based on a central tenet of intersubjectivity; and being wakeful (Clandinin & Connelly, 2000).

In terms of doing no harm to participants, Clandinin and Connelly (2000) advise that as research texts are composed, being thoughtful of the research participants as my first and most important audience is paramount for taking due care in composing "a text that does not rupture life stories that sustain them" (p. 174). Anonymity is a slippery consideration raised due to the fact that "even when we guarantee anonymity, it is not at all clear that we can do so in any meaningful way" (p. 174). Therefore, I was "aware of the possibility that the landscape and the persons with whom …[I was]… engaging may be shifting and changing… [and] what once seemed settled and fixed is once again a shifting ground" (p. 175). Questions related to who owns stories tends "to be framed quite directly in terms of whether the characters named in the inquirer's story own the story or whether the inquirer owns it", especially when anonymity is impossible (p. 176).

As Clandinin and Connelly (2000) suggest, although such a complex consideration tends to be framed in terms of ownership, a reframing into concerns of relational responsibility is a better approach. Based on a trusting relationship with my participants, sensitivity to what was revealed about participants and how what was revealed in text is read are examples of how questions of responsibility guide telling the story versus not telling the story. I am reminded of the words of Clandinin and Connelly (2000) who state, "the landscapes on which we work are storied" and "as researchers on those landscapes, we will be storied by those with whom we work" (p. 177). Thus, as a narrative inquirer I was sensitive to the stories of who I was as a researcher within the inquiry and within each inquiry relationship. This required responding relationally to concerns within researcher stories the best I could and listening to the stories told by participants of who I was, as well as composing those research texts.

As I puzzled over the stories that I, and we, co-composed in the field, which later intensified while leading up to and composing research texts, I became concerned because "writing a story or recording an event in a field text is conditional …on our interest and surrounding circumstances" (Clandinin & Connelly, 2000, p. 179). Clandinin and Connelly (2000) raise an important dilemma by wondering about what may seem like fact, over time may appear more as memory reconstruction by the participants or researcher. Are these reconstructions fact or fiction and for whom, and to what extent? Such questions may not have an answer, but caused me to think through issues of fact and fiction as I continued to read literature focused on autobiographies and memories. The *Letters of Virginia Woolf* edited by Nicolson and Trautmann (1979), for example, read like fiction. As I read this book, I began to understand better the issues of facts and fictions as matters of fictionalizing and disguise. With regard to the risk, dangers, and abuses of narrative, Clandinin and Connelly (2000) remind the narrative inquirer to be their own critic, and to "listen closely to their critics as they enter the field and as they compose field texts, interim research texts, and final research texts" (p. 181), given that every response is valuable in some way and requires distinguishing important points from useless ones. As Clandinin and Connelly (2000) state so candidly, "To dismiss the criticism that narrative inquiry is overly personal and interpersonal is to risk the dangers of narcissism and solipsism" (p. 181). Lastly, narrative inquiry is characterized "as a kind of fluid inquiry, a kind of inquiry that challenges accepted inquiry and representation assumptions…which necessitates ongoing reflection" (p. 184). Such work at the boundaries of narrative research requires narrative inquirers "to say which criteria they want to be used for judging their narrative inquiry…or develop new criteria that work for them" (p. 185). In any event, as I carried on with my narrative inquiry and continued to consider criteria that worked within the three-dimensional narrative inquiry space, I trusted in my *wakefulness* that it characterized the living out of my narrative inquiry in storied ways (Clandinin & Connelly, 2000).

Publishing and Presenting the Research

Criteria that I have considered in publishing and presenting the research, whether through journal, conferences, monographs, or lectures, relate to three main points. First, the research text needs to convince the audience that as a researcher, I have acted "in a responsive and responsible way… [reflecting] ethical practice but…also [sustaining] and [structuring] this practice" (Josselson, 1996, p. 283-284). Second, acknowledging that by adding to scholarly knowledge in the field as a result of making systematic inquiry public (research), one is also seeking personal gratification for one's professional and academic career (Bilu, 1996). Third, such a nontraditional approach to research as narrative inquiry has the potential to create experiences that result in feelings of "unexpressed longings, and the wound of regret…as our uncertainty and dependency on our [participants] is shifted into a position of authority back home" (Behar, 1996, p. 9). These narrating issues have provided me, and will continue to provide me, with opportunities to examine whether I have balanced my role as a narrative inquirer engaged in the reconstruction of meaning, with my role as ethicist engaged in the promotion of cultural relationality.

Next, I focus on considerations related to the process of inquiring into aboriginal stories of diabetes and the details of implementing *culturally competent scholarship* (Meleis, 1996). I believe that this intersection of particular methods (narrative inquiry) and an ethical framework (relationality) have provided me with numerous insights into the rigor of narrative inquiry as a methodology, and the evolvement of honor, trust, and respect within relationality as an ethic.

Achieving Rigor

Cross-cultural scholarship needs to establish and maintain substance and rigor as an integral part of research. In addition to drawing on the literature in relation to rigor in qualitative research (Guba & Lincoln, 1981), I also considered the work of Meleis (1996) that acknowledges the importance of developing culturally competent knowledge. In suggesting eight criteria for the assessment of rigor in research that is relevant to inquiries with people who may be disenfranchised, I considered criteria related to context, relevance, identity and power differences, empowerment, flexibility, openness, communication, and reciprocity. In not wanting to thwart the creative process of my narrative inquiry, I did not rigidly apply such criteria for establishing rigor. Rather, I approached the challenge of rigor in aboriginal research as being nested within the research decisions themselves. Such an approach returned again to the importance of what and how I thought about the negotiation of the research relationship throughout the inquiry and the significance of recognizing, understanding, and acting upon ethical concerns that surfaced.

The feasibility visit to Bella Coola prior to beginning the inquiry, which was associated with another study, assisted to ensure that criteria related to *context and relevance* were achieved. During this visit, I was able to appreciate an understanding of the diabetes context as a condition for Nuxalk people living in a rural and remote community and ensure that the proposed narrative inquiry was relevant to this particular aboriginal nation. The choice of a relational methodology that locates aboriginal epistemology within it provided ways to develop *awareness of identity and power* *differentials* that existed in the process of conducing research. An equitable relationship between the researcher and the participants was sought, through which the process of co-participation and co-construction of aboriginal stories of diabetes resulted in the *empowerment* of research participants. The four participants were honest and forthcoming with the *disclosure* of their stories, which in part, was facilitated by a flexible approach to *time* (Meleis, 1996). Such a temporal strategy enhanced the development of trustful and respectful relationships, the spontaneity that framed the scheduling of the conversations to occur, and the opportunity for their narratives to be told in storied form. The ability to conduct effective conversations was predicated on my understanding of the normative communication patterns in the society where the inquiry occurred (Briggs, 1986). I did not feel my understanding of *communication styles* of the four aboriginal participants was limited. Rather, this was enhanced by having worked and lived as a nurse in First Nations communities over the past fifteen years. Lastly, *reciprocity*, the final criterion for the assessment of culturally competent scholarship (Meleis, 1996), is implicit in narrative inquiry and both defines and guides the development of a continuously negotiated ethical relationship between the researcher and participants. Many times during the conversations I was asked by the participants and agreed to share my perspective on the current view of diabetes in terms of the extent and magnitude of the condition, causes and risk factors, the promotion of healthy behaviors, and clinical care and education. Soltis-Jarret (1997) views this self-disclosure as the responsibility of the researcher in order for collective understanding to be enhanced.

Concluding Remarks

My experience as a narrative inquirer was a dual one. I placed in the foreground the notion that as the inquirer experiencing the experience, I was also a part of the experience itself – being in the parade I was studying (Clandinin & Connelly, 2000). In studying the parade, I experienced tensions and dilemmas related to not becoming fully involved to becoming too involved. These tensions were inevitable, because narrative inquiry is relational. I not only became fully involved, but also opened my heart to my participants, yet stepped back and saw my own stories in the inquiry, the stories of my participants, as well as the larger landscape on which we were part. The idea that what was being experienced was co-constructed by me and my participants was always revisited. Then, diligently day by day, I composed field texts, interim research texts, and research texts derived from detailed attention to them as I slipped in and out of the experience I was studying, slipped in and out of intimacy (Clandinin & Connelly, 2000).

The choice of narrative inquiry methods was based on considerations related to the elicitation of life stories and the exploration of experiences that informed *diabetic self* stories. It was based on discovering within interpretive methods "the ability, or rather the art of being sensitive – sensitive to the subtle undertones of language, to the way language speaks when it allows the things themselves to speak" (van Manen, 1998, p. 111). As a result, reflective interpretations were revealed and organized across the four fundamental existentials of time, place, body, and relationship. Such explications were guided by the life narratives of each participant, within which stories of diabetes were nested. In the next four findings chapters, these narratives are presented in ways that illuminate cultural meanings based on the arrow of time, a sense of place, the inclusion of body, and the interpretation of relationship. An interpretive dialogue with the text follows each set of stories, writing which further elucidates how personal and human elements, as well as cultural and health dimensions, were captured. It establishes how through narrative our understanding of the aboriginal experience of diabetes may be temporarily deepened.

Now, I turn to Chapter Four, "An Aboriginal Self: The Arrow of Time" that not only reveals a dimension in which past, present, and future may be regarded as a continuous whole, but the existential concept further elucidates the ways in which a diabetic self is embedded within the person's own life narratives of experience. It recounts, viscerally and in words, the beginning of a journey I made in early spring to a verdant coastal valley in British Columbia. It was a place where light on the slope of the mountain cast images of stunning natural beauty. It was a time when my eyes played with light, paying close attention to new shapes on the horizon, to deep and dark lines painted by shadows, and to grandness of splendor and perfection that bathed me in silent mysticism. And it was a time when interaction of the personal and the social was made dynamic through mindful and emotional voices, which were not always spoken.

CHAPTER FOUR

An Aboriginal Diabetic Self: The Arrow of Time

In this chapter, the notion of an aboriginal diabetic self is revealed through the conversations I explored with George, an aboriginal man living with diabetes. Within the context of the narrative inquiry, the arrow of time not only reveals a dimension in which past, present, and future may be regarded as a continuous whole, but the concept further elucidates the ways in which a diabetic self is embedded within the person's own life narratives of experience. In building a trusting relationship with me, the researcher, over time George simultaneously began to explore the aboriginal diabetic self, thus enabling him to empower his own interpretive abilities of the lived experience that considers *diabetic stories* as being a reflection of one's *life stories*. I begin this analysis with George's narratives of experience *in living* with diabetes entwined with the ebb and flow of his life narratives. In addition, I show that by turning to the phenomenon of lived research experience I continue to learn how to look at the world by awakening the deep thoughtfulness that establishes a renewed contact with the basic experience of the world.

Plateaus, Mountains, and Valleys

~

Beginning a Journey

The horizon gives birth to land and sky. It holds above it a solar star that is the source of heat and light, anchored by the dreams of our ancestors who turned human acts into promise and hope. It starts as an apparent line that divides earth and sky and ends in the time taken and distance traveled to make a journey. It is a place where seeking to broaden our horizons and to contemplate what is on the horizon merges, and is made commonplace. It is the first day of March, my birthday, and I am 47 years old. My thoughts ponder this notion, revealing something foreign within my own journey, as well as something new within a projected one.

It feels strange to be getting older, and to be considering connections of significance between my life with certain points in time. It is peculiar to think about age and time, and to consider how I have chosen to spend the *time of my life*. I take solace in my plan of the day; the fact that I am on route and will be driving for nine hours through a paradise of breath-taking beauty. My destination is Bella Coola and it marks the beginning of a journey. It will take me across the undulating Chilcotin Plateau, beside the belly of the earth turned upwards that are mountains, through wide and narrow valleys sculpted by ancient glaciers, and into the experiential and fathomless lives of a few select others.

I feel the sun just above the horizon, warm and bright as it evaporates the dew of a new day. I am enveloped with splashes of bright color. Looking down at my hands I witness a display of prismatic light. Dispersing light into a colored spectrum, a rainbow spills from the transparent block of triangular ends and rectangular sides of my watch. I smile, savoring the fleeting moment, a display of shimmering, fragile optics. My thoughts rest on time, light, and the landscape, infused with their passing before me, like a movie reel, spinning in its wake frames of illusion and reality.

Arriving at Heckman's Pass will mark an uncertain point in my journey, as I will not know until I reach it whether or not the road will be passable or safe to drive. There are stories of people in their vehicles sliding off the edge. I view it as an invisible portal to a possible death, a potential brush with mortality. It reminds me of the crude uncertainty of life, of the unsuspecting bitterness we sometimes experience, and of fortuitous events that find us when we are the least prepared.

My attention is now drawn even closer to the horizon, the secure connection between land and sky. I remember back to the significance of this linearity, of memories piloting a plane. I recall the cloudless sunny day flying from the mainland to Vancouver Island. It was my first long solo cross-country flight. I relish in the liberating effects that freedom of flying delivers so poignantly, directly to the soul. It is a spectacular feeling from a view derived from being literally placed on top of the world that brings the self close to something unknown. Through memories I looked out into the beyond, a view framed by the wide window from sitting in the cockpit of a Cessna 172. And through recovered feelings my heart beat at the same time as I listened to the drone of the engine that kept me aloft. At three thousand feet above sea level, a lone woman crossing the deep waters of Georgia Straight, I imagined I was Beryl Markham in *West with the Night*. Her writing, more than a pilot's memoir, resonated with me, reminding me of the wise, humorous, and inspiring explorations of a life well lived, and its significance within me.

I drift back to my other horizon as the cool air escapes through the car window beside me, sending shivers through my spine. The tingling helps me regain the present, my senses relinquish a hold on past flying experiences. Instead, I turn to the memory of my departure from home just a few hours ago. In a peculiar way it feels like I am stealing back something that was taken away. I think memories are like that - the ability to relive a powerful moment. I steal back to being in a long embrace with Lee, my husband. The sweet essence of love lingers, precariously, on my mind and in the deep crevices of my soul. To be full of thought renders wholeness to life. I fill up also on the commotion I experienced with the tip of an exuberant tail, wagging, and the presence of our dog child, Thrasher. Instantly I am reconnected with her, as if sensing the lightness of an intangible feather moving softly against my mind's heart. I watched the three of us from outside myself, restoring an original sense of what it means to be in love with others in the world, to feel loved by the world. We were all caught in the vessel of time. And we tried to navigate our emotions through a galaxy of stars that kept getting caught up in the ambivalence of what it means to leave and later return to each other.

Reluctant and excited, I feel at the edge of uncertainty, clinging onto my readiness toward the crossroads of something new. I was now into a new phase of my dissertation work, a research field experience marked by the collection of data and the awareness of time, passing. The drive south is easy. High, white billowing clouds hang heavily in the sky. I discover a motif of running horses, appearing gallant within multiple layers of obscurity. Swirling currents of ground air dry the surface of asphalt. I look for ice. It appears shiny, but slick sheets can cover the road like a conveyer belt, prone to prey upon helpless winter tires, deceptively. I gaze at the snow that has fallen overnight. It is a view that is expansive and hypnotic. Whiteness extends forever, creating a landscape that is annexed from the other beneath it. Together, both layers reach around the earth – an enigmatic place separated by seasonal time. I feel sheltered, temporarily, from the tragic events harboring in the world; I am like a small boat that is anchored, snugly, in a far away cove.

I arrive in Williams Lake and welcome a chance to stretch my legs. I fill up with gas and complete the necessary car activities. Sipping coffee and eating dried apricots I drive west. Crossing bridges that take me over rivers, I watch the mountains create shadows as they block the sun. I follow the road beside them. Over the Chilcotin River I wind up in stages to high elevations and ensuing plateaus. I drive by ranches, homesteads, and crofts.

They are lonely hamlets, harboring people who thrive on and endure well, hard working lives.

I cast my eyes on the stunning beauty of Tweedsmuir Provincial Park, continuing along a vista of remote wilderness and melting snow. By late afternoon I arrive at *the hill.* I carefully negotiate the turns of a steep ascent to avoid the rocks that have fallen from above. The worst section narrows to one lane with no protecting rails; nothing preventing me from slipping into the chasm below. I glance at the branches of a towering pine as I pass it, wondering if it could break a vehicle's fall. Eventually, the route leads me through the last of the Coast Mountains and lowers me, dramatically, to the valley floor.

I breathe a sigh of relief, having made it successfully through the pass. I was spared the storms, events that mark unfavorable weather, for it could have been otherwise. But it was blissful today and instead of turning toward the Bella Coola Hospital, I carried on to the government wharf to observe its abandoned look of time. The cannery buildings instilled in my imagination an era of economic prosperity, which had been dependent upon huge schools of fish. Such bounty no longer exists. The tidal-flats stretch out for miles before me. They are home to all sorts of beleaguered logs and tree stumps, having been released from captivity.

I thought back to when we had brought Thrasher here at the beginning of the year. She ran like a crazed animal through soft mud and stunted grass, sniffing air that was arriving on salt-laden breezes. We walked on these tidal-flats with her. It was *dog magic* time. And it was the creation of *wonderful time.* As a family I knew we would return here in the spring - a strong desire to experience it all again at another time.

Turning into Nancy's driveway I parked the car, dropping the keys into my tired leather brief case. As I walked toward her front door she came out to greet me. I was surprised at how relieved I felt to see her. Nancy's smile welcomed me and we walked together to the house next door. It would be my home for the next few weeks, a place from where I could live out my research, and where I was to find time that would offer me new life possibilities.

Jasmine Green Tea

~

Sickness from Eating Dangerous Foods

Settling into the sofa beside the wood burning stove, I place a hot pot of tea on the table in front of us. George expresses an interest in the jasmine green tea as it steeps. "Thank you for coming, George, and for reading over the information and consent. I think the best place for us to start is for me to ask you, 'If you were to look back on your life, what stories would you tell to make sense of your experiences living with diabetes?'" I ask.

"That's a big, open question. There is sure a high percentage of aboriginal people got diabetes. I've experienced heart disease and diabetes together. I had a heart attack in 1994. About a year later I was diagnosed with type 2 diabetes. I don't understand why aboriginal people have diabetes. It's at such a high number now. How did it start in the first place? Why do we have it? I guess we may never, ever know how it starts," George explains, intensely philosophical about his well-being. He elaborates, "You see, you have got me at this stage. I am new to this. I was just diagnosed eight years ago and it is really hard for me to explain. What do I know about diabetes? Why do you want to ask me? How come you have never asked someone who has had it longer, someone who has been diabetic for about forty years?"

Although I acknowledge that forty years is, indeed, a long time, I indicate that from my perspective eight years is also a long time. We break out into spontaneous laughter at this revelation. "How come you never asked a person that had it really longer?" he asks. "Well I had to decide on how long would be necessary. And so I thought, well, if someone had experienced it for at least five years, they have a lot of experience about it to share. But someone who has it for one or two years may be a bit short. But five years or seven years, that's a long time. You've lived eight years with diabetes, and so you have a wealth of knowledge and experience. You have a wealth of experience related to your life, and diabetes is a part of that wealth." I reply. "Yes," George confirms, smiling.

"George, when you reflect back on the last eight years is there a period of time that was particularly memorable for you? Something that you remember?" I ask. George responds, "I don't recall, Sylvia. I honestly don't recall. I never dreamed I would ever get this sickness. I thought all the time about my heart problems. I was so concerned with my heart. Then all of a sudden the diagnosis of diabetes came. I was so uncomfortable when the doctor told me, 'George, you have diabetes.' I was so angry about getting it. Why did I get it? I did not deserve this. Now I had to work at it. I was diagnosed in Vancouver and angry with the doctor. He said, 'George, don't feel bad, you're not the only one. We have tablets that will help you and there is insulin.' But still, I had that angry feeling. It took me a couple of days to get over that anger. Then my wife said, 'You'll have to face it. You've got it!'"

George elaborates, "So at the session for the five days we were down in Vancouver, over at St. Pauls Hospital, at the end of the period I came out a happy man. Knowing that, at least, they are going to try and help me. Do what they can. Each year we go there. Some times we have good times and some times we have bad times. The last time was a good time, because they said, 'George, what have you been doing? What have you been taking?' They asked me the same thing regarding my heart. They said, 'George, you look good. You look great. Everything seems perfect with you this year.' But some other years I get 'run down', maybe depressed, probably depressed. That is what really 'gets me', being depressed."

I thought about George's depression. "Do you think that the depression tends to be a result of having the diabetes, living with the diabetes? Or would you say that it's unrelated?" I ask. "Unrelated," George replies. "I was depressed about having this heart problem so young, in my fifties, and the fact that it stays. I never thought I would get laid up with heart trouble. Then, to get diabetes a year later, I couldn't do anything. I could have been working. Food needed to be put on the table. I was depressed, getting angry once in a while," he explains.

I ask George if his heart problem started when he was younger. "Yes, ninety-four, it started August 26th of 1994," he says. "That's when you were told? What did they actually tell you about your heart?" I ask. "To tell you the truth about my heart, on August 26th of ninety-four, all I did was try to get a key for a friend of mine. I get in the car and it's game over," George says, snapping his fingers. "You had a heart attack," I say. George ponders then elaborates, "My friend rushed me to the hospital and I opened the door. The nurse says, 'What's your trouble?' I said, 'I feel like I'm getting soaked here.' He said, 'Come into this room and we'll see what we can do.' So he sat me down in the chair. 'Game over. I was done,' I thought," George said, snapping his fingers again. The words, 'I was done' reverberated in my mind.

"That's how you felt?" I ask. George explains, "Yes, I felt I was done. I was dead. I was dead for three or four minutes. So on the sixth day I woke up back in Vancouver in a green room. My wife was beside me. She says, 'You've been out for six days.' I thought I had been there just overnight. Next the nurse came in and says, 'Oh my God, you are a miracle man!' So we stayed there a couple of weeks until I was strong enough to get back home."

"You were in a different world, George, and that wasn't too long ago. What a crisis! Over night your life was different." I remark. George explains further, "Now to tell you the truth, when I see a child crying, I get a real 'soft heart'. Even when my grandkids are in the house and are crying. I want to cry too. I hurt for them. That is how much my life has changed after that heart attack. That is how soft I am. Or when I see a movie and tears come to my eyes. It just hurts me inside, really hurts me."

"You've become an even softer George. Was it the experience that you had, George? Of having a heart attack, being in Vancouver in the hospital, and the realization that you came close to not being here any longer?" I inquire. "Yes," he replies. "That's a profound experience," I indicate. George recollects, "To tell you the truth, when I had my heart attack, I never felt pain. I just went to sleep. I didn't feel a thing. I didn't even know they were working on me. I didn't know they had me hooked up to machines, but they worked hard on me. The doctor who came in to my room said, 'You had a close call.' I felt like standing on a stack of bibles and going on my hands and knees to thank everybody who helped save me. I said, 'Thank you.' The doctor said, 'No, don't thank me. Thank the ones in Bella Coola. They're the ones. They're the ones that saved you. Not us down here.'"

"Thank goodness for the small hospital, the doctors and nurses, and the quick response. So it sounds like this started you off on another path, within yourself, because of such a major health event. And then you were diagnosed with diabetes in 1995?" I ask. "Yes, 1995, a year later and a total surprise, two total surprises," George remarks. He explains further, "A year after my heart attack I was diagnosed with diabetes. This is what really set us in our habits of our meals. If it wasn't for my heart my wife would cook anything, but each time we would go to our diabetes session in Vancouver, we would learn something new. My wife goes with me every time and we would say to each other, 'Oh, we didn't know that. Now we know what to cook at home.' So that's helping us a lot. You see I didn't know fatty food was dangerous. I thought food was food to me. Bacon was bacon to me and sausage was sausage to me. I didn't know they were dangerous. I didn't know it was dangerous to the vein. I thought a vein was just for the blood, for the blood to go through the heart, and that's it. I remember the two doctors who sat down beside me on my bed in the hospital. They were a husband and wife team."

George points to the black round pipe attached to the wood burning stove in the middle of the living room. It is situated across from where we are sitting, radiating heat from which we derive a sense of pure comfort. He continues, "This doctor says, 'George, I'll explain to you a little bit about your vein.' I said to her, 'What happened?' She said, 'Your vein is like a chimney. When it gets dirty inside, you have to clean that chimney to make the smoke go through good. It's the same problem with your vein. That fat builds up in there and chokes it just like a chimney.' She also says to me, 'Are you going to smoke again?' And I say, 'No.' She asks, 'Are you going to drink again?' I say, 'No.' I promised her that I would never do that again. In fact, she gave me a call just about a month ago. I recall that talk she gave to me before I was released from the hospital. That is how she explained it to me about how dangerous foods were. I never knew. The way she explained it was beautiful. It was just like a dirty chimney. You've got to keep it unclogged. That is how she put it."

Was it during this year and then later, when you were told about the diabetes, that you started to make some changes in your life?" I ask. George explains, "For the diabetes I take my pill every day just to keep things even, and it's working out perfect. The hardest thing for me about the diabetes is that we can't eat what we used to. I can't eat what we had before. My eating habits changed. I would eat a lot of fish. A couple of weeks ago, for example, I was invited out to a turkey dinner. I said, 'Make mine half a portion.' The server said, 'No, we don't give half portions here.' 'Oh, what am I going to do?' I thought. So I just ate half. I don't want to embarrass them by doing that. I didn't say, 'Your cooking is no good.' It is still hard to go into a restaurant, because I crave what other people are going to have. You see I have to take porridge over bacon and eggs." George laughs, continuing. "Then there are the nice fried potatoes. I take my 'poor' little porridge, my sugar free stuff, and my one percent milk. I have to eat the diabetic way. I am living the diabetic way."

"Sometimes I feel angry when I'm eating diabetic food, because I look at some foods and I say to myself, 'I could have had that,'" George says. He explains further, "You see my kids, they love their ice tea. It comes in these little packets in different varieties. My wife makes them up and puts them in different little jugs. I have to use lemonade with no sugar in it, but I look over at that ice tea and it's tempting. I say to my wife, laughing, 'Grab me, grab me, please.' It's just like an alcoholic you know, craving for their alcohol. But to tell you the truth, I am not tempted like I used to be, because they make the ice tea sugar free now. So when my wife bought that box and I tasted it, I said, 'Oh, that's not bad. It's almost the same as what the kids have got.' But the kids love their ice tea. I say to them, 'Girls, be careful, be careful of that. Don't take too much.'"

"Having choices is so important isn't it?" I ask. "Yes, because you must crave for sweets sometimes?" George asks in return. "Yes, I think I crave for certain foods at certain times," I reply. George elaborates, "I find it interesting that a chocolate bar doesn't seem to harm me. But if I eat a cup cake with icing on it I say, 'What is in that cup cake that builds my sugar level up so high and quick? Is it the oil, the flour, or the icing?' It's amazing what all those things together will do to me." I respond, "Isn't it interesting that it's not just one of those things, but probably four or five things in the cupcake that are so finely processed, high in fat, and high in sugar that make the difference." George agrees, "All those things together." What a complex little thing that cupcake had become.

Pride of Ancestry

~

An Elder with Spirit in His Body

"Is there anything on your mind, George, as far as our conversations go?" I ask. "The sessions are beautiful," he says. "Has it been ok? I think we've had fascinating conversations," I comment. "Talking to you I want to ask you. When you talk to an aboriginal person, do you feel the spirit of them? Do you feel like that with some elders? If you talk to an elder and they talk about spirit. Do you feel any effects of them?" he asks. I reply, "Yes, I feel those kinds of experiences. I feel very nurtured. I feel a connection. I feel my humanity in a different way, if that makes sense. The connection is different. And I found that once a certain amount of trust and respect has been established, and the good intentions are there, it's a wonderful experience."

George elaborates, "When I first came here in 1963, I was 24 years old. I fished with an elder for a few years, and each time we fished through the valley, he always had different stories of the valley. And he'd laugh long. He was hard to understand, because he was an elder. He was over his eighties, probably close to ninety. For his age he sure had a good memory of the valley. How we used to fish! And me at my young age, I'd say, 'One of us believed. One of us believed in this valley.' As days went by he would tell me more stories. His words were kept in my mind. This man is something. He's got spirit in his body. Truth is being told."

"How old were you, George?" I ask again. "24," he replies. "Very impressionable," I remark. "Really impressionable," he confirms. "Have you taken those stories with you throughout your life?" I ask. George explains, "This elder left such an impression on me. I don't know his language, but he doesn't know mine, too. He would say, 'George, next time we go fishing, you stand in the stern of the boat and start dancing when I sing.' So, we went up the river where the fish started. He starts singing and I start dancing away. And he said, 'Lots of fish hitting the nets. Dance harder. They're going to hit the nets harder too.' He was just kidding me, but we were laughing hard."

George continues, "This elder, my father-in-law, and I would have so much fun. They were beautiful times. We'd be out on the water for hours and hours, days and days. He would phone me. He used to call me 'son', saying, 'Lets go for a drift today, son.' I'd say, 'Yes, ok, lets go!' And away we went. I can still hear his laugh. I'd say, 'What's the matter pops? He'd reply, 'Oh I'm thinking, thinking what the fish are going to tell me today. The stories he told me were very impressive, beautiful. I wished I had a brain that could have kept these stories in my head. He traveled and trapped lots. That reminds me about a time we both almost drowned. We didn't watch. We weren't careful. He said, 'Boy, hurry up, pull!' I looked back and he was sucked into a log jam. I just reached in for him, but he went under. Sucked under a rafter. I said to myself, 'You and me pop. I'll try my best!' I grabbed him. I saved his life. It was a gift.

"You were actually in the boat and it hit the log jam, capsizing?" I inquire. "Yes, it capsized," he replies. "Isn't that amazing, though, that time the two of you spent together, and how his stories and the time you spent were gifts to you? And you saving his life was a gift to him," I reveal. George expounds further, "I missed him when he died. He was a good singer. He sang for the elders at potlatches. He had a beautiful voice. But he is still with me. I tell my son about him. My son is bigger than me. I take him out on the river. I try to teach him how to mend the net, how to hang them, but he's a young man. He doesn't know yet. It takes a lot of training, mending nets, and hanging them, how deep to go. If you're ever around here in March or April, we'll go fishing together! Whenever they come around, spring salmon. I'll ask my son if we can go."

A Tough Life

~

The Good, the Bad, and the Ugly

"George, what was your life like when you were young?" I ask. "I was born in Bella Bella on November 26th, 1939," he replies. "My mother was deceased after birth, after she had me. Fortunately I had four or five grannies. They looked after me. As my grannies left, my Auntie Margaret took over to look after me. So we traveled from Bella Bella to the North Pacific, Kitkatla, Sunny Side, Cassiar, Port Edward, and Rupert. From there I left Rupert at the age of nine down to Alert Bay residential school, which I served, maybe, seven or eight years. I don't recall. I stayed there for a few years, then went back home to school in Bella Bella," George explains.

George continues in a soft emotional voice, "Alert Bay was very difficult because there were so many Nations in there. Every one of us spoke our different tongue. It was hard to adapt. Sometimes kids would talk their own tongue. So I talked my own tongue. I don't recall what my own tongue was, but when I spoke one time, the staff come to me. I was pretty young. One of the staff was punishing me and slapped my mouth for talking my tongue. So he said, 'Anyone in here? Can you interpret for me, this young boy? We don't understand him.' So this big guy come. He said, 'Well tell me George?' I spoke my native language to him. I said, 'Ok, I'll say it in English.' And he said to me, 'What's the matter, George?' I said, 'I don't like that other white man.' He said, 'Why?' I said, 'He slapped my mouth.' And then the staff said, 'What did he say?' So my friend, Charlie, went to explain to them. He said, 'He doesn't like you. You slapped his mouth for talking his language. He is only talking his language."

George takes a deep breath before continuing, "As the years went by, it was like the good, the bad, and the ugly. I guess there were different charges in staff and how things worked out. We didn't know abuse was abuse. We didn't know the staff would take us into his bedroom, two at a time. We didn't know. We were kids. We didn't know any better. There were other nights in our dormitory, which was a huge dormitory for more than two hundred kids. It had three levels. There was junior, intermediate, and then the seniors, all the way up. So I never knew, all the things that happened as the years went by. Sometimes things were good, really good, and then sometimes things were really ugly."

George clears his throat, recalling, "Different years went by. The staff changed, somebody taking over for someone else at Alert Bay. Different staff had different personalities. There were ones who could be kind. But there was this one guy. He was from the army and he'd take out his big army belt and whip us. 'Cause he served the war or something, he treated us like we were soldiers, like we were bad. He was brutal with his belt. 'Cause he was in the army. I guess the meanness was in him. When he came to our school, the residential, he treated us like the way he was treated in the army. I remember one time. We'd get a hard biscuit at night. You know those hard, really hard, tea biscuits, those thick ones? We were always really hungry. We'd get one of those at night before bedtime and just that, no milk, no tea, nothing to wash it down with. Just a hard biscuit. And to tell you the truth, you know the tank of the toilet, the bathroom toilet? We used to push the big bulb, push that thing down and kind of submerge it, and the water would come by it. That's how we drank our water. We were so dry."

George explains, "And the 'bed wetters', they were all in one line, one row. That was a hard one to face. 'Cause I was ok. I never did wet my bed, but some kids were frightened and scared. When they went to sleep they'd pee and then they'd get a whippin' the next morning. They were so frightened and scared. One time, a friend of mine said, 'George, if you wake up before me, wake me up so I can use the bathroom.' I said, 'If I wake up?' He said, 'George.' I said, 'What?' He said, 'I tied my penis.' That's how frightened and scared he was. He actually tied his poor penis so tight that he said, 'If I pee, if it tightens up, I'll make a run for the bathroom.' I think that's why they peed more, 'cause they were frightened. They were frightened of the strap. In those days we got the belt or the boot. The staff would say, 'Get up! Fix your bed again!' Then they might kick you."

"Meals sometimes would be pig," George continues. "A pig has lots of fat on it and they didn't even shave it. The hair was still on it, on the bacon. And they would boil it that way. Do you think you could eat that? And we had to eat because we were hungry. We were hungry most of the time. They didn't feed us enough. You know, if we had a quarter, Sylvia, a quarter or a dime, you'd ask the next person, 'Can I buy your bread? A slice of bread for a quarter?' We were so hungry. Then there was the good part of it. If your girlfriend knew where you were sittin', she'd put an extra, nice layer of peanut butter on your bread. But if you ever had an argument with her, you'd get nothing." George wipes the moisture from his eyes. "I think about those times, often. It's a long time ago. They say that scar will never heal. Maybe thinking too hard about it gave me ulcers. Then I had cancer of the colon, followed by my heart surgery and the diabetes. I guess I just worry too much, thinking too hard about my life, worrying about the family."

"How is your tea, George?" I ask. "Great, beautiful," he replies. "Thank you for talking about the residential school. I realize that it is very emotional for you," I say. George responds, "I never had a very good life. It was tough, when I look back at it. But I have to live day by day now. It's so nice to have our grandchildren. The twins though are beautiful, so young. Their whole lives in front of them, and twins as well. Amazing! So we spend a lot of time with them."

The Good Old Days

~

A Life of Fishing & Hunting

"When you were finally able to come home and not go back to the residential school, George, what was that like for you?" I ask. "Bella Bella has changed a lot," he explains. "It was a one way boardwalk when I left in my twenties. It was just a one way boardwalk. That was the highway, their highway. But now I see only, maybe, four or five streets. And it goes right down to the bay. It's beautiful, rows and rows of homes. But still, I wouldn't go back. When I returned from residential school I spent some time with my granny and my auntie. My dad was still alive but he wouldn't look after me. I don't know why. But my dad had a seine boat and he lied about my age, so I started fishing when I was fifteen or sixteen. Fishing was good but it was hard work. I got experience from my dad on how to run the boat, how to mend the nets."

"Did you have to get to know your dad again?" I ask. "He told me he was my dad but I didn't know him that well, because my auntie brought me up," George replies. "My auntie and her husband brought me up. My dad, he gave me his picture. I showed it to my auntie, but she got mad. She said, 'No, that's your other dad. You're our boy.' So I was confused, a confused boy. I was twenty-four when I moved to Bella Coola, or maybe a little older. I fished with my dad off and on. Then I went halibut fishing way out in the ocean. And then I did the same with my uncle. I then gillnetted by myself with my own boat. Never got rich, but I tried."

"I was married for about eighteen years," he continues. "It was another part of my life. We couldn't make things meet, my wife and me, make ends meet. So we divorced. She divorced me. She is partly from Bella Coola and partly from Bella Bella. We had some children, two boys and a daughter. I have three beautiful children. They're adult age now. So during those years I was married, I was raising three children and fishing. Later I became a Fire Chief here, until this accident I had with my heart and had to retire. But when I retired they gave me a phone to be 'on call', just to take the calls. Like an old man, I still go out and supervise once and awhile. I guess it's in the blood."

"Then there was the loggin', packin', and guidin'," George says. "Over at the cannery, I worked there for quite some time. And I worked for quite some time as a logger, logging. In between each I guided with Clayton Mack, went loggin', went packin' over there. And in the fall I'd go guidin' for my father-in-law again, just to pass time away, cooking, skinning a bear, listening to his bear stories." I ask, "Tell me more about your father-in-law, George. The two of you would actually go out hunting for bear?" George responds, "My father-in-law is quite the person. I call him dad. The two of us went hunting for bear. Sometimes we would challenge each other. And I'd say or he'd say, 'George, there's a big one over there. You want to try and tackle him? Chase after him?' And we'd take off."

"I can't imagine being that close to grizzlies," I remark. George explains, "Oh there are times when grizzly hunting is dangerous, especially if you wound them. If the hunter don't kill them right, they'll get angry. Oh yes, especially if you chase them right away, wound them right away. And if you go after them, they'll turn on you. So my father-in-law says to me, 'George, if you ever get a shot that wounds a bear? Don't bother him. Go back the next day. Just leave it.' And I said, 'Why?' He said, 'Any bear that is wounded will be more stiff tomorrow.' So that's what happens. The bear can't run. He won't be able to run. He's stiff from his wound. If you were wounded or get hurt, get bruised, you don't want to move. You can't get it healed right away. So you got to lay around and give it time to heal."

"I learned a lot from my father-in-law," George says. "It was beautiful, just beautiful. You know what Devil's Club is? There's this big, green devil's club. It's got a lot of leaves on it and is really prickly. Some of them stand quite high. What happens is, when you get a wounded bear the leaves will droop down. My father-in-law would ask me, 'Do you know what is stuck under the leaves?' When you get a wounded bear it will rub that Devil's Club onto its wound when he's making a run. And when his heart is pumping his blood gets clotted and there's a big jelly of blood on there. And that's what made this leaf fall down, just a little weight on it."

"And I said, 'Dad, how do you smell it?' He said, 'How do you mean?' I said, 'How do you smell that bear? You seem to smell that bear wherever he is?' He started laughing and turned around. He said, 'Son, do you see that leaf like that?' I said, 'Yes, dad.' He said, 'Lift it up. There's a big clot of jelly under it. Just that little bit of weight will put it down like that.' He's walking ahead of me and he's lifting the leaves up like that. And I never knew. I was always watching every move he made. And I said, 'Dad, how do you smell it?' He starts laughing. He said, 'Lift that leaf.' And there was that big clot of gel on it. You know how animals get that clot of blood? Because those leaves are high, the bear has to be pretty big. And he said, 'Wait, wait! See those leaves are down now. It's plugged. His wound is plugged!' I said, 'How do you know dad?' He said, 'Do you see that little speck of blood. It's on the leaf now. It's above the leaf now, a little dot of blood.' I could hardly see it."

"My father-in-law knew where the bear was," George continues. Sometimes the bear would walk a straight line or he would run up the hill. The reason he ran up the hill was to die or if he was wounded to dig and dig around where he's going to lie down. So we found that little speck of blood. And he turned to me and said, 'We've got to leave him now. So we leave and my father-in-law says, 'Son, do you remember that last drop of blood we seen. Do you remember where it is now?' I said, 'Yes.' He said, 'Ok, tomorrow we're going to find it again.' So the next day we could see the bear was down the hill. We walk by it real quiet. You know what? That bear was looking for us. But we're smart, not me, my father-in-law was smart. He said, 'Son, do you know what I mean, now? Look over there.' The bear was looking at us. My dad said, 'Ok, if we climb that hill from where he's looking, the place where he lost that blood, remember that one little spot? If we climb that hill he has more of a chance to kill us.' You know what? Bears can run down faster than running up. They're in a full charge. We would never catch him because he was too big, clumsy, because he has all his weight. He would just come charging and it would be game over. That's the one story I like. I like that one!" I looked at George amazed.

"Through all the years with Dad, we traveled long distances," George says. "Out in the bush, like what I said, Mom has got some photographs. I'll look around for them and show you. And I'll tell you a little more as we look at them." "Does the bear have a special meaning for you, George?" I ask. "As far as the bear, to tell you the truth, I really kind of hated killing them," George replies. "I had to do something to live, to help my father-in-law. There was a little aching there. That's why I went along with him, just to help him. But he was doing that for years and years, before I met him."

"Oh he taught me lots, taught me well! One of the things I could never learn from him was sharpening knives. He can make it so razor sharp. I could never do it. I tried. I said, 'Dad, how do you do it?' He made them so razor sharp. He said, 'I'm just used to it.' He seemed to just grab the thing and cut the hide so easy. I'd be tryin' and tryin', but his, it was just like a butter knife. I couldn't make any headway with mine. I just couldn't sharpen it the same way. You have to get right down to the nails, the lip and eyes, ears and if you don't do it right, it will rot," George explains. "It takes a long time. Then you soften it down and try to get it to wherever they fix the hides, right away. We don't eat the bear meat. Some do eat the bear right away when it comes out of hibernation. But after awhile, when it becomes 'fishy', it has tapeworms. You would be afraid of trichinosis. The hunters take the bear hides, make a rug or he makes it stand up." George continues, "Guiding, though, was a good part of my life. One of the things about nature is that it's beautiful! Have you ever spent your time out with the birds and the animals, in the sun? You're at peace. You're listening to the raindrops, listening to the birds, it's paradise. You can throw a crab pot overboard, have fresh crabs. Nature will feed you. It's a separate part of my life, a good part of my life. I enjoyed every moment of it. When we would travel around and I would be holding the wheel of the boat, Dad would tell his stories, sometimes over and over. Every time we'd go out I'd say, 'Oh I heard that story, carry on Dad. Just do what you want to do. I'll hold the wheel. I'll cook the meal. Whenever you're ready you can take the wheel and tell your hunter story again.'" George laughs. "And it was, indeed, good to hear it again," I thought.

Reflecting on the Past

~

After My Heart Attack Came Diabetes

"I don't know about you, George, but when we have conversations like this, I start thinking more about my past," I remark. "Has it caused you to think more about the past, too?" I ask. "To tell you the truth, I was laying down late last night and trying to think back. My father, I wonder if one of us started things off right, if I said things right. It's been a long time. You know, you're thinking back, way back and trying to explain things. It's very difficult to remember and what to say about it. But yes, I can say something about this. It's so important to me. I never ever dreamt that I'd be questioned about my lifestyle. You're the first person to ever approach me about it. Maybe I tell my wife a little about it, but not as far as this," George replies. "Is it alright for you?" I ask. "Yes, it's good," George confirms.

"There was a pause in between my heart attack and the diagnosis of diabetes," George explains. "I didn't know what I was going to face. I never knew. I never knew what I was going to deal with. I just never knew or felt what kind of sickness I was going to get from this diabetes. I don't recall when I went to the hospital here and they tested me out, but they did send me down to Vancouver. That's when I was really diagnosed as being a diabetic. There was this class. I remember going to the class, me and my wife.

We went to the diabetes class. But before that I was diagnosed in the clinic. The doctor said, 'George, you're a diabetic.' I was angry. I didn't want it. I didn't know what to think of it. 'But we can help you with pills. Cut down on your diabetes,' he says. But still, the anger was there for a couple of days. I really didn't want it. It's just like saying to you, if I was a doctor and I said to you, 'You're a diabetic.' How would you feel?" George asks. "I wouldn't want to hear it," I reply. "You wouldn't rejoice and say, 'Oh good!'", George says laughing. "No, I would not want to hear it," I say.

George elaborates, "I heard of some person, said they didn't even know they were diabetic for years. They thought they were just overworked, tired. This fellow living up the valley, he's passed now. He said, 'George, darn, I live off the land. I'm a farmer. I work hard. Now all of a sudden I got diagnosed with diabetes.' It was hard for him." George continues, "And when the eating habits came. I missed the good eating," George says laughing. "What it used to be like to eat?" I ask. "Yes, what it was like to eat. But to tell you the truth, I don't miss it, like bacon and eggs. My wife now cooks porridge, toast, and sugar free jam," he says. "Was that a hard year for you, adjusting to life after the diagnosis?" I ask. "For a while it was hard, because it meant we had to face it, taking out the things we couldn't have," he says. "And your wife had to change too?" I ask. "Yes, she eats what I eat now," he replies. "Is that important to you?" I ask. "Yes, you see, it runs in the family," he says.

"Is it true if you're a diabetic, it runs in the family?" George asks. "Is it true? I know it doesn't happen all the time. The reason I ask is 'cause my brother-in-law, he's diabetic and my wife thought it might run in the family. He has been going to the classes in Vancouver. He finds the diabetes not as easy as mine. But it did that to me too. I would go down to the classes and it never was quite the same each time, different doctors and nurses to see. But it gets broken down a lot, having the diabetes explained to us. That has made it easier. If it wasn't for their help I guess I would have been going the same way, eating our old way."

"Our eating habits would have been the same if we didn't go to diabetes classes," he acknowledges. "There certainly is a lot to learn. Always figuring out what to eat. What changes to make," I remark. George explains, "You see us Native people, most of us live off the land; and mostly fish. And we get the odd deer or a piece of moose meat we get from some place, then we trade it. My sister-in-law works in the hospital and once in a while she preserves jam for me, sugar free. It's beautiful, you can't tell the difference. You can't tell the difference, honest. It might be cherry, dried cherry jam, blueberry jam, or apple jam. You can't taste the difference, even strawberry jam. All of it is sugar free."

Facing Up to It

~

Times When I Felt Depressed

"Before I had that last heart attack I was more or less like an alcoholic," George says. "And many a times you get anger. You want alcohol all the time. And when you run out of booze you get depressed. I tried marijuana. That didn't work because it made me more cranky. It just wouldn't agree with me. And then I had my last heart attack. That's when I just quit, quit everything." George explains, "I was age 14 when I started. I knew lots of people who were doing it. If my friends could drink, I could drink. You know, it's always the same, let's go have a party and then it's happening many times. It was depressing to do this bad habit, especially when I had marriage problems. It really didn't help. It made things worse. But when I first had the taste of alcohol I wanted more, and more and more. I just couldn't control it. Maybe at times I could control it and sometimes I would go overboard on the weekends. Mostly on the weekends there would be a party. That was in my twenties and thirties. Now I feel good!" George says. "I faced up to it. But I remember back to it when I see somebody who has been drinking, like last night. I remember those that feel it still do it. But I also remember being 24 and married, with two boys and a girl."

"George, when I think about you having that heart attack, were there times you felt depressed?" I ask. "Yes," he replies. "And you were married with your second wife at the time?" I ask. "Common-law right now," he says. "You were with an important person when it happened," I remark. "The lady I'm with now, she's more like me now," George continues. "After I had this massive heart attack I went home to see my Mom. She said my wife went to the bar and had one, and she said, 'You know, no more!" "Your wife quit drinking?" I ask. "Yes, she quit too. She smokes but she won't smoke in the house. She quit the booze though. She was in her forties," he replies.

George elaborates, "My wife is happy. Her kids are happy. Her daughter has got beautiful kids. They're happy. I'm happy. Her daughter would say, 'Mom, boy it's good to come into a smoke free house.' She wouldn't smoke in the house. She'd do it in the car, but not in the house. But the oldest daughter, she knew. I remember we used to fight every weekend, but we felt guilty too. Why were we doing this, taking it out on our kids, drinking? They knew better than us. After my heart attack I quit drinking and quit smoking, right at the same time. I didn't want to feel what I felt when I had that heart attack. I just didn't, but when I woke up in the hospital, oh boy, out for many days. I couldn't stand up. It was a miracle to get through this. It was beautiful to see the earth again."

"This was a real shift for you George," I say. "Yes a real shift," he concurs. "It is amazing how the heart attack and the awareness of diabetes happened so close together. They both are quite woven together." Did you realize what you were told to change in your life was similar for the heart as it was for diabetes?" I ask. "I didn't really face that," George replies. "The only thing the doctor told us was to be very careful of our eating habits after that massive heart attack. And how to prepare our food. I just seen it on television tonight." George laughs. "Those beautiful hamburgers we used to have, those fries," he says. We discover ourselves laughing together. .

"They're always advertising them," I remark. "Yes, sometimes I think I just want one for the taste of it," he comments. We laugh some more. "Do you find that you are now careful of what you eat because of the heart attack and the diabetes, together? That it is the same?" I inquire. "Yes, it is the same focus," George says. "There was such a real change in your life at that time, wasn't there?" I ask. We pause. "Yes, I actually had to start on a new path," he replied.

Wishes

For the Love of Our Children

"My kids seem to be a lot closer to me now. My daughter had her birthday on August 26th 1994. And that was the day I had that massive heart attack. Somebody said to her, 'What do you wish for your birthday?' She said, 'For my Dad to come back.'" George clears his throat and with tears in his eyes reaches for a tissue. "Yes, it's all she wished," he says. " And she got her wish too, so special," I say. "Yes, she got her wish. So that made me think more about my kids. It was what she said to me, 'All I want is my Dad. For him to come back, to come home,' he says. "Is she the youngest daughter?" I ask George. "Yes, she's our little girl. My daughter has a little girl. This is her, right here," he replies, pointing to a picture of his granddaughter on the front of his cotton shirt. I read the words out loud, 'Grandpa's Little Angel.'

"Yes, she's the one. Before I had that trouble, she'd always run up to me. She'd say, 'Papa, Papa!' She'd grab me. Then when I left she missed me when I was in Vancouver. When I had that heart attack. I was down there for two, two and half weeks. I came home. She was lying on the couch, just relaxin'. There was my granddaughter. That was so wonderful to see. She laughed, jumped on me. You know, her little grip around my neck. She held me so tight. Yes! And she's growing now, she's growing. She's about seven this month. She asks me, 'Papa?' 'Say what?' I reply. 'You know what I'm going to be when I grow up?' she says. 'No honey, what?' I ask. 'I'm going to be an anthropologist,' she says. She's just a tiny little thing. And it just came out of her. I don't know where she got it. You know how kids are. They come out with the weirdest things sometimes. And that's what she said. And my son-in-law, he's just shakin' his head."

"So I have eight grandchildren, including my wife's. Beautiful! We had one of the little girls with us this morning. And at six o'clock she's crying. I put her on my tummy. You know, putting a child on your tummy, when you're thinking hard. So I put the little twin on my tummy this morning, up here, over my heart, and the heaviness, it's gone. It's just like she healed me. Thinking too hard I guess. And smell her beautiful little body, a baby smell. It's the most wonderful thing you can ever smell, a beautiful little child. We look after one of my wife's daughter's twins. She sleeps between us on the bed. Her mother looks after the other one. So we take turns getting her a bottle. We'll wake up, but I don't know how to make the milk. My wife does that, but I'll feed her the milk."

Praying to the Creator

~

Learning about Diabetes

"I've been going to Vancouver to the diabetes workshops since 1995 or 1996," George says. "Every six months we were down. We get a little paper about our attendance at St. Pauls diabetic workshop, about our sugar testing and our progress, a report card, beautiful! It's a couple of days. And we listen to other diabetics' remarks. Like if you're diagnosed with diabetes I'd listen to your side of the story just like you're asking me," George explains. "How come I can't eat popcorn when he can eat popcorn?" I say. George laughs. "That's what comes up. 'I like my popcorn with a little bit of butter. Now I can't even have the darn stuff.' You know the elders? They love their popcorn. 'Now I can't watch the darn TV without the popcorn,' they say." George chuckles.

"Yes, both my wife and I go now. We used to have my heart check up and our workshop together. It makes me feel good when they tell me, 'Hey George, you're doing fine. I don't know what you're doing. Your color is good.' But sometimes I can look really good outside but inside there's heaviness. Maybe stress, maybe a bad dream, you know. Like when I told you. Remember when I told you if I see a child crying, I want to cry. Or I see something sad on TV. I get this big lump in my throat. Honest to God that's the way I feel," he explains.

"You know a prayer is a wonderful feeling to have. Even when my Mom calls me long distance away but she talks in our language. And I understand the Creator when she talks in her tongue. Heilsuk, I speak a little, but I forget now. 'Cause it's been so long since I've been at home. But she looks at me with that funny grin. She says, 'Do you know what I said?' And I try to piece it together." George laughs. "I explain to her, ok, now I remember," he says.

"I'm not a religious man. I'd say spiritual. I go to church but I don't like being forced into it. I go when I feel like it. I pray, pray to the Creator, pray for my grandkids. Making sure they don't get sick again, 'cause we lost a little loved one, one time. I don't want to see that happen. Yes, my stepdaughter lost a little boy just eighteen months. His little bladder, there was something wrong. I don't remember what happened. But she got a gift. She's the one who's got the twins now," George explains. "They are a gift to her."

George elaborates, "But praying makes me feel good. I ask my mom, 'Mom, I'm a Heiltsuk. I'm a Heiltsuk. Pray, pray for me in our language.' I ask her. 'I'm a Heiltsuk. Pray for me.' She says, 'Ok.' Singing makes me feel the same way. I used to sing a lot. I used to try and sing but my voice is so rough that I can't. It's harder to sing now. Yes, I wish I had my brother's voice. He's got the voice. I used to sing in residential school. I tried. I came third in a recital, but I never tried hard enough to keep it up."

Being a Fire Chief

~

Conversational Layers

"You have a very interesting life, George," I remark. "You think so?" he replies. "Yes, absolutely," I confirm. "I never ever thought of it that way," George says. "Oh yes. The resilience, there's a lot of resilience there. There is so much to you and how you view the world. How you came through your heart attack and how you live with diabetes, balancing all that," I emphasize. George thoughtfully considers my words. "Ah huh?" he asks. "Yes, it's tremendous. Not everybody can do that," I reply. "Nope," he acknowledges.

"People seem to do it in different ways", I add. "Like how?" George asks. "Like some people don't manage very well," I reply. "Yes," he agrees. "Or they get depressed and they don't want to change. They know what they should do, but they just can't do it," I explain. "Just like I was telling a friend of mine," George responds. "Hey, I did my reading this morning. It's not too bad. It was good. My friend says, 'I gave up on the damn thing now. The hell with it.'" George looks at me intently. "So, what's he going to face? Is he going to get gangrene, going to get blind? What is it? Are his kidneys going to go? What's the first?" he asks.

"Well, if that sugar is high all the time it's going to destroy his body. And very often it can affect the eyes, because the little blood vessels in the eyes get damaged. And his kidneys, the small capillaries and vessels in his kidneys get damaged," I explain. George agrees, saying "He lost his toes from gangrene." I explain further, "Yes, the blood vessels in the toes, because they're very small and those high sugars circulating around cause damage to the blood vessels. And so with your feet and its small vessels, the sugars destroy those vessels and there isn't enough blood getting to the feet and toes. So the tissue dies." George continues, "Yes, some people find it really hard. They just don't want to do anything with themselves. To tell you the truth, if I see them in a restaurant, order a 'potine' and put a lot of salt, gravy on it. That's no good. I notice when the salt comes out," George says, laughing. "Because I don't use salt. Soya sauce light I use on my herring eggs."

"As we continue our conversation I elaborate, "It's hard to change our behaviors, but you strike me as somebody, George, who still loves life. You're enjoying life and you have people in your life who are important to you, who you love. And you want to continue to experience that." "Yea, it was just like when I was a Fire Chief," George explains. "Many times people ask, 'Why are you doing this?' 'I love my people,' I answer. I've seen my people burn. I've seen my kids burn. It hurts. Somebody has got to do something." I affirm his words, "And you did. You had to act on things that were important, because you loved your people." He continues, "Yes, I seen a friend burn in his house. I couldn't sleep. I just closed my eyes. I could see him smiling at me. He always had this beautiful smile. I could see him." George pauses to swallow. "He burned in the house."

"I seen kids burned in their houses, no hands, black. Mother ain't there, couldn't get them out. The reason I started was because our fire department was way down in the town. It didn't have enough men. This was quite some time ago. I know there were 39 of us started and there's just two of us ended off. Now we've got whole fire trucks, firemen. It's still on a volunteer basis, but there are more people now," George explains.

"But you started from the ground up. It's a part of who you are," I remark. "Yep," George agrees. "Rising to the occasion. You see there is a problem, something needs to be fixed and you act. You feel responsible and you act on those feelings," I indicate. George considers those words in the moment. "We traveled all over the world. I mean not the world but all over, like Nanaimo, Chilcotin, Rupert, and Prince George," he says. "Yes, with the fire department, it was good. We had our little competitions. I had a great time with them." I asked George if it was an athletic kind of competition. "Yea, we'd set things burning for training. And we'd win a suit, fireman's gear or breathing apparatus, axe or boots, hat, flashlight, pump, and computer. You name it we got it! There were good prizes in it. Actually all my kids were in it back then," George recalls. I think about how good it feels, sometimes, to reminisce.

A New View of Eating

"You look well rested, George. Is your blood sugar good today?" I ask. "Yes, beautiful. I don't want to see it high. I don't like seeing it high," he replies. "It doesn't sound like it's been high for a long time. You've got a nice, steady routine going," I remark. "And these talks have been still okay for you, George?" I ask. "Beautiful," he says. "I went to a service last night. It was beautiful! I like their singing. I like that kind of singing. But I don't like their praying!" George emphasizes. His tone causes us both to laugh. "Their singing is okay?" I inquire. "Their singing is good but when they start praying, that's not my style," he says. "Were they praying last night?" I ask. "Yes, and screaming," George says. We laugh. "Was there a group of them singing? Nice harmony?" I ask. "Beautiful! They're all from Kincolith and different places. All First Nations and they travel around," he explains. "Well, great that you had time to go over for a nice evening." I remark. We pause together, comfortable within another visit together.

"We've talked a little bit about what causes diabetes and there's a lot of ideas around it. When you think about it, George, what are your ideas? Do you think about what causes diabetes in people, generally, or in First Nations peoples, specifically? What do you think is part of this picture?" I ask. "Part of the picture of diabetes," George says. He lingers through a long pause. "It's kind of hard to say or explain. Why do people catch it so easy? It's not the contact, it's like what we were taught. It's our eating habits. I think it's our eating habits," he says. "Yes, that seems to be a starting point to consider, doesn't it?" I ask. "Yes, like what I said when I had that massive heart attack. I didn't know food was dangerous. I didn't know fatty food was dangerous. I thought bacon was good for us. I thought, 'You know, it never, never, ever, never ever, ever dawned on me that when we eat that it goes through our system, our body. I thought it just went through the stomach and you dispose of it. I never dreamt that it would go through our veins, that fat, the fatty food,' George says.

"And then do damage," I remark. "Yes, yes. And then do damage. And I didn't know it. Here I was pouring grease all over my rice and potatoes, and I didn't know the danger of it. If I knew I probably wouldn't have done that. It was already too late then, when I found out that grease was dangerous," George explains. "Yes, it's a total switch in understanding," I say. "Yes, it's like a friend of mine. He had the same problem last month. He said he didn't know. He has eighty percent blockage of his system and he went for a holiday and, bingo! He had the same thing happen as me," George exclaims. "He had a heart attack?" I ask. "No, he never had a heart attack. They caught him in time," he says. "Oh, good, but he had chest pain?" I ask. "Yes, yes, they put those little wire things on him and I don't know what they call it," he says. "An angiogram?" I say. "Yes, they put one in," he says. "And he had blocked vessels," I say. "Yes, right, right," George answers and ponders. "Yes, people learn about that damage when they're older. So we're kind of working backwards aren't we? But the diet sure seems to be a part of the picture," I remark.

George elaborates, "That's the only way to go is your diet and eat healthy. Keep away from the fatty foods. Fatty foods like pork chops, sausage, hamburger, and fatty meats. And when my wife prepares food she cuts all the fat off the pork chops. Before we used to just fry the whole thing on the pan and it would be crispy, crispy bacon, but no, no more! When she cooks hamburgers she puts it in the pan with some water and boils it and then strains the fat off."

"Good for you! That cuts down the fat a lot," I remark. "Yes, that's how we were taught in Vancouver in our classes. You know if it wasn't for the classes we would be cooking the same way," George indicates. "Yes, we need information in order to change. To know what to change. Our diet is so different these days. It's changed so much over the last fifty or sixty years," I confirm. "Like barbecuing in the summer, I see all that waste dripping onto the grill," George says.

George reminds me of a past experience I feel compelled to share with him. "I was in Portland a number of years back. I was going to school there and the hospital I was doing some work in had a small shop that had all sorts of health information in it. As I was walking through there one day I noticed a small display. It consisted of about five plastic cylinders mounted on a wooden board. There was solid fat in each one. In one cylinder there was about an inch of fat, and another one had two inches, another had three inches and so on. At the bottom of each cylinder were labels indicating what food it represented. The first one was a half a cup of ice cream. The second one was a McDonald's hamburger. The third one was a hot dog. The fourth one was three slices of bacon and so forth. Shown was the amount of fat, solid fat, in the particular portion of food. I couldn't believe it!"

"Okay, which one was the highest? The hamburger?" George asks. "The hamburger. And the ice cream had a lot too. They all seemed four or five times more than what I had pictured in my mind. Amazing!" I say. "How about when you live off the land, like deer and moose? I think there's a difference in fat. Yes, don't you think so?" George asks. "I do," I reply. "It's a little dryer than what we get in the store," he remarks. "Yes, it's leaner. You mentioned, George, that you trade fish for moose meat and caribou," I say. "Yes, my son in law, he got some deer and we'd dice it up. We took off the fat. Threw out all the fat. We just had straight meat," he explains. "And that's how the diet used to be, especially for First Nations people. When you ate fish and a little deer meat," I say. "Like my uncle, when he used to go trapping, he'd come home with about twelve geese, and that was our treat, geese. And I used to favor geese over turkey. Mom would pluck it and burn it. It would be nice golden brown, beautiful!" George explains.

George elaborates further, "Must be something really different with turkey, 'cause I heard on the news that if you're to have turkey this winter, prefer fish over turkey. So what is in turkey? That much fat, or is it what they feed the bird? 'Cause they feed them pellets with steroids so they can grow faster. Like my old folks, my grandfather. I don't know if you ever ate black ducks. We used to eat black ducks all the time. When I was a young, young, young boy, we ate seagull eggs, seal. We had seal meat, seagull eggs, and black ducks."

"Are seagull eggs big?" I ask. "Oh yes! They're big. Now the kids would just look at you, 'you guys ate that?'" he replies. We both laugh. "But that was our diet," he says. "Yes, these days we get ostrich eggs. Some people are growing ostrich and they're huge. I've never had them, but it makes me think about how really different it was in the past. How First Nations people used to eat a lot of wild fowl and wild meats, and wild berries. You see, we could have salmon eggs, dried herring eggs, seaweed, dried seaweed, abalone. And then there's red snappers, ling cod and halibut and this was before our time.

But now we have 'Supervalu'!" George indicates, laughing. "You had to live off the land to survive."

"Do you think that has something to do with diabetes in First Nations?" I ask. "'Cause we never heard of diabetes a long time ago. And all of a sudden it sparked. It sparked like cancer. Poof! Grew like and followed with cancer," he replies. "What we eat is certainly important. It's a puzzle though. When you think about your situation, George, what do you think might of contributed to you getting diabetes as you look back?" I ask. "I wouldn't know," he replies. "It's hard to know, isn't it? It's complicated. Were you aware that your diet changed over the years? Compared to when you were a young boy? Was it quite different?" I ask. "When we were kids we never used to see potato chips, right? And all this fatty stuff," he replies. "Yes, and sugar stuff - pop, candy bars and candy. It seemed like in the 1950's that things really changed. We were able to go to the store and just have all those choices," I remark. "But you look at it this way. It's not gonna get any better. There's gonna be no cure, it's just gonna carry on. Same as the heart, I seen it on the news. I like listening to the news," he explains. "Yes, the health news on television. There are so many food choices right there at our fingertips. If there's no restraint it's a free for all," I say. "I went to a diabetic class when the Co-op food store was going full bore, and the restaurant was right in front of everyone with all the goodies. And that's the first thing your eye went to when you opened the door. Well, well, well!" George says laughing. "All that food! Yes, it's almost easier just to close the door," I suggest. "And what can you do? It's real hard," he admits.

"Before when I couldn't control it, it seemed to be high," George explains. "There's a difference when it's high or when it's low. And when you're in between the high, medium and the low. And you wonder why and then you forget. You forgot all about it. Oh, I'm a diabetic! Or when it's high and I want to go straight for the bed and lay down. Then I'm wondering why and when I wake up it's, 'oh my gosh', I forgot. Then I take my reading and it's okay, there's my problem. But now, like when you ask, it's best to take your reading and then carry on from there, adjust it. Yes. Like we're supposed to have four little snacks a day. And that's my biggest fault. I forget. Like I'm out fooling around down in the canyon and then time goes by and then I forget. 'Cause my mind, I want to get this wood home. I want to get it chopped up. Get it home and forget. And then when I'm chopping the wood and I start to get sick. I say, 'Oh my gosh.' I say, 'My sugar must be getting low.' I'm sick and barely making it up the stairway. You see, I've got fourteen steps of stairs to climb at my house. It's high!"

"You really feel it then," George explains. And I don't carry candy or anything in my pocket. Maybe if I carried a handful of candy, I'll just keep on eating the darn things!" he says, laughing. "That can be a tricky thing, deciding on what kind of snacks to put in your pocket. What would you think would be the ideal thing? Some dried fruit or a granola bar?" I inquire.

"I never ever thought of anything. And yet we took all this up in the workshop. It's just that I forget to take things," George replies. "Yes, and sometimes it's having something convenient to take with you. Like deciding, 'okay', it's going to be the apricots and the granola bar today," I explain. "Like I used to drink cream soda," he says. "And now I don't even touch it. I have diet Pepsi or something. 'Cause cream soda's really sweet," George recalls.

"Did you used to drink that when you were younger?" I ask. "Yes, yes!" he replies. "Yes, it was a real treat for me too. It was so red," I recall. "Yes, red, sparkling!" George adds, chuckling. "What kind of snacks do you tend to have now at home and in between meals, George?" I ask. "Sometimes I'll have a slice of bread and peanut butter. The one where you really got to mix it, hey? The thick, natural kind, not Kraft. 'Cause that's got salt, but the natural stuff, it's got the oil on top. It's dry, really dry. It's hard for me to mix."

"I bet you get your wife to mix it. She's got the muscles," I remark. George laughs with me. "One just has to give some thought to what kinds of things you can put in a little bag, and to stick it in your pocket, even if it's half an apple, or something. But it's all about the sugar, keeping it in that middle range. So it took you a while to remember that the way you were feeling was because your blood sugar had dropped. And then after a while it became routine for you. I guess it's kind of like training your body, isn't it? Training your mind?" I inquire. "You've got that right," George confirms. He leans back, sinking into the sofa.

It's Not Going Away

~

Being Caught by the Disease

"Does it seem like a long time since you were diagnosed with the diabetes, George? Or does it seem like yesterday?" I ask. George replies, "Seems like a long time, the last seven years. Sometimes you try not to think of it. Seems like when you think of it the worse it gets. It seems that if you put anger into your life your sugar level rises, right? One person said to me, 'You know, George, I did everything right, the wife cooked everything right for me and my darn sugar level was high.' And I said, 'Did you get angry with anybody? He said, 'Yes, my grandson.' Then I guess his blood pressure went right up and it triggered him off."

"Is that right?" George inquires. "You bet," I reply. "And the only thing for me, the only thing I could find out when I get like that, when it's really bad is to do a little exercise, go for a walk rather than the truck. If you know it's high, go out, go out! Like my friend, he's a big man, bigger than me, and he's diabetic. 'George I have a hard time keeping my count down,' he says to me. First of all he's living too close to the fridge. He can just go and open it and sit down and watch the television, right? And then I said to him, 'You go for a walk?' He says, 'Yes, I walk in the house.' We laugh together. 'But that's from here to the fridge and back,' I say. 'You got to go out and really walk or really bike ride,' I say to him".

"I think being active helps a lot, because like for me, these past few days I've been on dry land, puttering with the boys and getting firewood for next winter. Be active!" George explains. I pour jasmine green tea into his cup. "Your tea is very good," he comments. George continues, "But you see, some people they don't get it. They don't care! I'm afraid of what I've seen. Like people losing their toes and their eyesight. I don't want it. I've got enough problems of my own as it is, my heart, and I don't want to lose any more. You see, I've been opened up from here right up to here. That's enough." "You're very motivated, George. And you care. You care about yourself," I reveal. "I try my best. I try. Sometimes I maybe try too hard," he says.

"George, what has it been like for you to learn about how to control your diabetes from doctors and nurses, and the health care people? Especially when you think over the last seven years. What has that learning been like for you? George answers, "If I didn't learn or go down to Vancouver and have these sessions, maybe I would be getting worse. You know what I mean? If I didn't go around and learn about controlling my diet, like I told you, I don't think I'd want to face taking insulin by needle. I'd rather take a couple of pills than give myself needles all over my body. And for them to teach us in Vancouver is magnificent. I don't quite know how to put it, but it's quite unreal!"

"It worked for you. And you've been every six months?" I say. "Like what I told you, that when I went back down last time they did praise me up and down. What have you been doing? What have you been doing right? And I was afraid to face that," George says. "Face that assessment, a kind of evaluation?" I inquire. "Yes, especially when it comes time where we can prick our fingers with a needle. Each and every one of us in class and I cross my fingers and say, 'Oh, I hope mine's not really high. I don't want to see it high. I don't want to see it twelve, you know?' It's all up here." George explains, pointing to his head. "It's just like me talking myself into it," he explains. "Into a low sugar? I inquire. "Yes!" George exclaims. We both burst out laughing. "And it was good, your blood sugar?" I ask. "It was beautiful. George reveals. "And then when the doctor called me into her office and said, 'Take out your machine.' I took mine out, crossed my fingers, hoped it was gonna be low. Then she says, 'You got one machine and I got one. Now which one's telling the truth?' My sugar level was way lower on her machine and mine was a little on the high side. So there's two levels again. I said, 'I'll go with your machine!'"

George clapped his hands and we both laughed. "They're sure not perfect machines." I remark. "And then they check your nerve points. They look at your toes and eyes. It's really a good check. Then there's getting on the scale." George laughs. "Oh, now how can I make myself light?" George says, laughing deeper. "I bet you were thinking, 'If only I could be light as a feather,'" I say with a chuckle, indulging in each other's humor.

"So that was a good thing for you, George, talking to the doctors. They were really happy with your progress. I bet that made you feel really good," I indicate. "See, when I first went down to Vancouver I was angry. I was angry because I had this disease. I didn't want it. I didn't ask for it but I got it," George explains. "It sounds like it took you a while to accept it. It sure doesn't happen overnight, does it? Did you find you had to sort of grow into it?" I inquire. George nods his head. "How long did that take, George, before you felt you were getting to a point where you were growing into it?" I ask. "Oh, it took me a while. I'd say a couple of years. It was like a growing pain, hey? I have to baby it just like my heart. I have to baby two things, my heart and my diabetes."

"You can't heal yourself overnight. It's very different," George says. "And then you got to a point where you felt more accepting of it?" I ask. "Right, right," he confirms. "Do you think it had to do with how other things changed?" I inquire. "Yes." George ponders. "What do you think made you accept it?" I ask. "You get to that point. You say, 'I have to live with it,'" he replies. "It's not going away?" I inquire. "It's not going away. Day after day you wake up with it, right?" George looks at me intently. "You feel you might as well face it?" I ask. George explains, "I look at my self and say, 'I'm not the only one that's got it. Anyone you see, you look around in class. They all got the same disease I got. And none of us are going to get better with it. I notice that some of them are angry when they are having their lessons. 'What did you eat this morning?' 'I eat what I want to eat!' You know, just like that!"

George laughs. "And you can understand how they feel?" I inquire. "Yes, you could see it," he replies. "They're in a different spot. The anger is there initially and then it begins to just be less and less. And you get better at controlling things and understanding things. And then you can accept it?" I ask. "That's right, Sylvia," George replies, pausing to reflect on the words.

"Looking back, what comes to mind when you think about the most valuable thing you learned in terms of your diabetes? What was one of the most valuable things that happened?" I inquire. "The most valuable thing. I don't really recall. It's hard to say," he says. "Not just one thing but a lot of things?" I ask. "It's probably a lot of things," George replies. "You've mentioned that information was essential. When you could see that making some changes, choosing different foods, for example, resulted in influencing your blood sugar?" I ask. "Right, right, " George confirms emphatically. "That must have made you feel good," I respond. "That's why you go. You go stage by stage," he explains. I thought about George's experience. "You really feel like you've got a handle on things, don't you?" I ask. "Right," George replies. "To a certain extent, initially, it controls you and then you get to a point where you're controlling it. Somewhere along the way the tide turns," I say. "Right! That's a better place to be in," he remarks.

That evening I reflected on how George had described *being caught by the diabetic disease*. There wasn't anything that happened along the way that he acknowledged as a real setback to him. He was always taking steps in a forward direction, from when he knew he had diabetes to knowing how to change the things that were required along the way. Every day George seemed open to learning something new that resulted not only in *being caught by the disease*, but also in *being able to just move on*.

Cause You Can't Cheat

~

Starting All Over Again

"George, we've talked a lot about eating and changing your diet with diabetes. And you talked about controlling the diabetes and feeling a little angry, getting to a point where you were accepting it. What did you and you wife start with as far as the diet changes? And what things continued to change as the years went by?" I ask. George explains, "She cooked the way she normally cooked, but me, my portion was small. Just my portions used to be big. So we, we're starting all over again. In my classes they're telling us to try and cut back very slow on your portions. And now it comes to the point where my grandkids were eating more than me. That's how far I got. I just did one little scoop of rice or a little scoop of meat and a scoop of corn. And then I carried on, just like in Vancouver.

One time I was invited for turkey dinner. 'Please make my portions small,' I ask. 'No, we don't give half,' they say. And that made me kind of angry again. When you see a big full plate you want to eat the whole thing too, hey? And then I don't want to see my reading after that. And then it kind of embarrassed me to eat half the fat, 'cause there's people at your table that ate all their dinner. And here's half of mine on the table. What can you say? What can you do? 'What's the matter, you proud? You never ate your meal!"

"'George, you did the right thing. You did the right thing,' my friend said to me. 'But why were you trying to order half?' she said. 'I'm diabetic. I can't eat it all,'" George recalls. "Was that something that you could grab onto initially? You starting with smaller portions, but then going slowly at it to a point where you didn't have to go any lower?" I inquire. "Yes, and then I try eating vegetables raw but I get a 'tropical map' on my tongue. I don't know what's in those vegetables. My daughter's the same way," George explains. "What happens to your tongue, George?" I inquire. "The tongue just gets lines, red lines on your tongue and they call it tropical map, I don't know why. But it hurts when I eat," George replies. "Is it all raw vegetables?" I ask. "Oranges does that, fresh orange would do it," he says. "Oh, the citric acid maybe," I remark. "Something sure triggers me off!" he says laughing. "But cooked vegetables are okay?" I inquire. "Cooked is okay," he says. "And fresh fruit is okay?" I ask. "Yes, fresh fruit's good. I eat banana, apples, but they do the same thing, give me a little kick, a spark," he says. "So the portion and then the types of food were changes for you?" I ask. George explains, "You see I'm supposed to watch my eating habits, watch my weight, do my daily exercise. They tried to tell me to cut back on my water, but I like drinking water. I don't think I drink that much water now. If I'm up at four in the morning I like to have a crispy glass of water."

"There's so many things to change with diabetes. But you've got a good routine down now, George. It's taken you a while to get there, but you're there. You're amazing!" I say. "How many people you think could do that?" he asks. "Oh, that's a good question. I think it's all over the map. But you're amazing, George! You have a good handle on your diabetes. You've been able to put the pieces together, make sense of what is happening to you, and make those necessary changes. You're in control of your diabetes. You've grown into that part of yourself now. And you seem relaxed about it. Would you agree?" I ask. "Yes, I've accomplished a lot," George replies.

Turning Back the Clock

~

Keeping an Eye on Me

"George, during one of our conversations you had mentioned that you felt like you never had a good life, a very good life, as you look back. Would you like to talk about that a little?" I inquire. "I'll have to maybe really think hard about that. 'Cause at the age of 63, we're turning back the clock again. And trying to remember all the things I went through, all the stages of my life. Sometimes they were happy times, and then there's a lot of sad times, hey?" George replies. "Yes, life throws us a mixture," I remark. "Yes, a mixture in there," he says.

"And I guess it depends on what we're actually gazing back on. Has it been okay for you to gaze back, George?" I ask. "Yes, yes! I was thinking. I wish I was a good writer and write the things down from the time I went to school, the things I went through. And then compare it to your story when you come back. But I don't think I'll be able to," he explains. "Or maybe just see where our story goes, how it unfolds," I say. "Or think backwards. They say if you go in the woods somewhere and just scream your anger out, it helps. I don't really know. I haven't tried!" George comments, along with his laugh. "This is just a thought, but what about writing a letter to me or yourself. That's just an idea," I suggest. "Like what I said, I'm not a very good writer. You see, that's my problem, is writing. Even when my sister writes to me, I write it and put it aside. I can read all right but writing is very hard," George reveals. "Yes, writing is hard. It takes a lot of practice. But having the kinds of conversations we've been sharing together is much better," I say. "That's why I said when you come back we'll fill in the gaps. Maybe I could think of more things?" George asks. "Memories are like that, they just come," I reply. "Yeah, 'cause these stories have got spirit in them, healing. When it gets right down to it, diabetes is up to the person," George remarks. "And you've come such a long way," I tell him.

"I just want to thank you again for being so interested in this work!" I emphasize. "It's interesting," George says. "Yes? And you've enjoyed the conversations?" I ask. "Yes, yes! I certainly have enjoyed them. Oh yes, especially now. When you first came I was kind of shy and I didn't know what to say. Then we opened up and really talked about things. It's interesting, you know," George explains.

"Well, George, you're a very easy person to talk with and have conversations with. I'm hoping that other folks like yourself, who are experiencing diabetes, when they read your stories, that something might trigger with them, something might spark," I indicate. "Yes, just like the other day when I was mending my net, working on my net, and a friend came and I went to help him with his net. And a dog was eating grass. And I said, 'I wonder why the dogs eat grass? They're not cows.' My friend says, 'That's their medicine.' I said, 'I wonder if we ate grass if we'd get better, too?" George says, causing us both to laugh. "Yes, every living thing has to have its medicine, really. And finding out what our medicine is, is a part of life. As well as enjoying ourselves along the way, because life is short. We're not here forever," I reveal.

" No, to tell you the truth, no. It's just like a root stuck, trying to hang in there. As long as we can," George says. "And enjoy life. Soak up the day. Just like you are when you're on the river. Being able to spend some time here in Bella Coola. It is such a wonderful place because it's a beautiful spot on the earth. I think it's one of the most beautiful spots on earth. These mountains are just glorious. And when you're on the river and you're fishing, there is no other place you'd rather be," I emphasize. "Yes, you've got to watch on Sunday. At six o'clock you'll see a whole pile of people up there. You watch them. They just drift down in their boats, dragging their nets, fishing. It's a wonderful sight. You see, what's going up now are the Springs, hey? Next will be Dogs, Chum going up; then Sockeye. And later on probably Coho. October is the Coho, lots of Coho," George explains.

"What do you see for the future, George, as far as your diabetes goes? I ask. "Try and live as long as I can," he answers. "Yes, doing what you're doing," I confirm. George explains, "Take care of your life, don't over do it. I got some beautiful grandkids that opened my eyes, they did. Try and take care of your life. And take it easy. We never know what's gonna happen tomorrow. Even though we got a long ways to go, try and reach that goal. I don't know what kind of a goal. I'm ahead 'cause they said I only had ten years to live. That was after my operation. So that makes you think. When am I going to go? It's very fortunate for me to wake up and look at daylight. I say, 'Oh, I made it, dear God. You know what I mean?' Every morning there's something. I wake up. Sometimes I wake up looking at the baby and smiling at her and it's a precious thing to see. Life is so precious that I figure you should just try and hang on to what we've got right now. Try and reach that goal. Before we're called home."

"I think it was my Mom's faith, it was her faith. Faith has a lot to do with your health too," George adds. "And even my father-in-law, when he was alive. When he was alive, he said, 'George, could you do me a favor?' I said, 'What? Anything'. He said, 'Phone home to your Mom and tell them I need prayer.' So I phoned home. She didn't hesitate and she started praying in our language. And I understood right away. She didn't hesitate. She started and I went down to tell him Mom prayed."

"Where did she get her strength, her faith from, do you think, George?" I ask. "Through my Granny. My Granny had a lot of faith," he replies. "And it came down through to you," I remark. "It just passed on. I think she's gonna be about the last one at home now that ever says prayer in our language. And then there's going to be no more, no more listening to her," George explains. "Her spirit will continue to live on through the younger generation. Their different journeys," I say. "Right, different journeys," George agrees.

"When I think about all our talks that we've had, I've gotten a really good sense of who you are, George, and who you've become. How important the people in your life have become. The experiences that you've had over your life have influenced you and influenced the people who are close to you. You've shared with me such powerful life stories," I explain. George continues, "I'll just say that whoever you are, just try to be yourself and help other people if they're stuck. I try my best. But before, like when I told you, I didn't care. Didn't even care about other people. But now that I've straightened out I care. I see. There's a second light there somewhere."

George elaborates, "Yes, there are times when I think back, I cry. It wasn't just me. It's not just me I'm crying for. It's the rest of the children in the residential school who I had seen and the person that did it. I could picture him whipping us. Oh boy! I could see him whipping me. Every time I closed my eyes. As far back as I can remember. You see when we went back to that place years later, when I told my wife, 'Let's go upstairs and I'll show you where we got 'lickings'. Where we got abused. And I could stand on a stack of bibles and tell my story over and over and over. It'll never change," George reveals. "It'll always be there?" I ask, gently. "Yes, it'll always be there. Always be there. The only one I really talked to is my wife. And I try not to think about it. Until I told you about Harrison Hot Springs and that movie on residential schooling that I saw. That pain! That's when the pain really came out again," George explains.

"Yes, you going through an experience like that and then re-visiting it, it's painful. But it's a good thing in the long run. It's helpful because it's not building up inside, eating at you. It becomes less of a burden on your heart, on your soul," I reveal. "See, with my life I had operations for ulcers, operations for my heart, and then diabetes. There were times I said to my wife, 'Just tell the doctor that maybe I've had enough of being opened up. Just put me in a casket and take me home.' Because my body can't take any more. But I sure pity the ones I went to school with. They remember. Even though it was supposed to have been a Christian school. You know you wouldn't think that it could have been that way," George says. "Well, it was madness! It was really madness!" I stated. "You know they seem to hide behind that bible. You went to church and they talked to us, but the minute they'd close the door behind you, in that residential school, it was a different story," George explained.

"George I'm so glad that you're experiencing a peaceful time of your life now, with your wife and your grandkids, in Bella Coola. This is a beautiful place to be. The air is good. The water is good. It's spring. The fruit trees are blooming. You live in such a rich valley. And you're more at peace with your spirit now," I explain. "When you go down to the river, Sylvia, be sure to bring your camera down there, you'll see those fish! Sometimes they jump out of the water stuck on the net. Try and catch them right away if you can. Some you'll see right below you. I'll probably see you down there. My son will probably fish with me tomorrow. Just once in a while I go just to get it out of my blood or have a little exercise. I try not to overdo it. My son says, 'Dad, what are you doing in the river?' I say, 'Son, it's in my blood. I got to go once in a while!'"

"I guess while we're talking. Is there any difference, comparison between my stories and other people's stories," George inquires. "Oh sure! There are some similarities and some differences," I reply. I share with George some of those life threads. "I truly see what you mean, because I seen two ladies that lost their eyesight. And I seen an elder here, he's gone now but he was a diabetic. He had a big sore on his leg that was, how do you say, like gangrene?" George asks. "Yes, gangrene. No circulation," I remark.

"Just like it went rotten. You could see his bone. So a few years later he had it amputated. And I said to myself, I don't want to face that! Even when you see it in true life. When you see the ladies in true life, getting blind, because they didn't take care of it, the diabetes. If only they took care of their life. So to tell you the truth, I don't want to be blind. I try to see the world as it is right now and to see things improve and see lovely things and see my grandkids grow up. You know, see the beauty in the world. If I close my eyes I wouldn't be able to open a door, right? Why do some people not care? Why do some people not care about their life? We are God's gift," George explains.

George elaborates further, "To tell you the truth, Sylvia, I'm very fortunate to have met you and the stories we shared, I hope it'll help you. And I'd like you to keep up the good work you've been doing. If it wasn't for you people, doctors and nurses, I wouldn't be standing here today. I wouldn't be talking to you. The things that happened to me. With my heart I would have been gone if nobody was close by me. This is the kind of people we need on this earth, to share our stories, our pain. I'd like to thank you very much, Sylvia."

"Oh George, thank you for saying that. I can't tell you how enjoyable this has been for me to have met you and for us to have the time to have these conversations. You've been so interested in this research. And I could not have done this work without you. Your experience living with diabetes and your life stories are such valuable stories. Our conversations have been very meaningful to me," I explain. "I hope my stories help you a lot. What I remembered," George says. "They are wonderful stories, George. And I feel so privileged that you wanted to share them with me," I respond. "Now is it time to take that picture?" George asks. "Yes, let's take a picture. It's time!" I reply.

> I let the fish go and it rests in the shallows next to me. In that moment I sense the timelessness of nature and the fatalism of the spawning run. I know that the rivers I love are paved with the bones of the fish that I love and by this I am bound to the planet. The dazed steelhead stirs, its tail roiling the surface of the great Bella Coola River, and then it swims out, vanishing under the sheltering forest. (Hume, 1998, p. 176)

In what follows, I examine the stream of time, cultural time, the sugar clock, time at play, the echo of time, and images of time by way of George's narratives, which give new recognition of the subjective, intuitive, and spiritual dimensions of an aboriginal diabetic self.

Stream of Time

> Time glides by with constant movement, not unlike a stream. For neither can a stream stay its course, nor can the fleeting hour. (Ovid Metamorphoses XV, 180, In Coveney & Highfield, 1990, p. 7)

Within the subject of an aboriginal self, the dimension of time is foundational to understanding the experience of living with diabetes. To consider time may take the form of witnessing it moving in one direction, from the past to the present to the future: a stream that surges forward unrestrained, a glass that shatters becomes something else, leaves that fall from a tree shrivel and disappear. This perception of time is to consider the arrow of time – the past, present, and future regarded as a continuous whole – and how we directly experience it in our lives. And it is to contemplate succeeding moments as if they were the sands of time flowing away like the unraveling of delicate fabric – the loose strands of our existence (Carr, 1986).

A specific point in time may be expressed in hours and minutes: *What time are you going to take your blood sugar?* It may be perceived as a system of reckoning for expressing time: *The deadline for taking your diabetic medication is before meals.* Time may be experienced as an unspecified interval: *I was doing well with my diet for a time until my sugars went up.* It may take the form of an instance or occasion: *When was the last time you saw the doctor?* Time is a sufficient interval or period: *I need time to think about what I ate.* It may be an occasion or period of specified quality: *We had a beautiful time at the diabetic workshop.* A suitable moment may be considered time: *The time has come for me to accept my diabetes.* And time may be considered a period or point marked by specific attributes or events: *During times when my diabetes is stable I feel fine* (Butterfield et al., 2003). The awareness of time in our daily lives does in fact move like an arrow; it shoots forward into what is genuinely unknown and leaves the past immutably behind (Coveney & Highfield, 1990).

George reveals coming to terms with his diabetic self, that is, internalizing his experience of living with diabetes by making connections to the *loose ends* of life and the harmonies derived from the relationships with others and the environment. Over time, he has attempted to make such connections as if they were essential to an understanding of living with diabetes. Of course, as a person experiencing a diabetic life he has not always been so adept, but with time George has acquired a deep affinity to such self-learning, in part, through an evolving spirituality. An understanding of aboriginal epistemology sheds light on this apparent affinity.

Forbes (1979) suggests that knowledge without a spiritual thread is susceptible to developing into a disconnect between learning and doing, because learning remains superficial at the skills and facts level, where understanding is devoid of morals and values. I suggest the creation of residential schooling is an example of such a formation without morals and values. Meaningful learning, according to Forbes, is "learning ... how to live a life of the utmost spiritual quality" (p. 11). Such connections among learning, morals, and values are fundamental to aboriginal identity. Consequently, George understands how he is connected to other human beings and to nature. He understands that the relationships with others in his life are governed by their intentions and motivations toward him, and are crucial to the strength and quality of such connections, his identity, and the *diabetic stories* he lives by.

Couture (1991), too, reveals how aboriginal identity may be understood as a state of mind centered on the compassionate heart. He elaborates on this notion of *being* aboriginal by stating:

> Traditional Native holism and personalism as a culturally shaped human process of being/becoming, is rooted in a relationship with Father Sky, the cosmos, and with Mother Earth, the land ... This relationship ...[is] marked by a trust and a respect which stems from a direct and sustained experience of the oneness of all reality, of the livingness of the land. (p. 207)

George's identity is based on his spirituality, his inner space, and his interconnectedness with the world. Cajete (1994) explains that for aboriginal peoples, the notion of interconnectedness is also related to what may be understood as *spiritual ecology*.

Spiritual ecology is understood in the context of authentic relationship and meaning that is discovered in the natural world and understood in the deeply rooted human connections present *within* a person's inner space. As spirituality, Ermine (1995) reveals such space as "that universe of being within each person that is synonymous with the soul, the spirit, the self, or the being. The priceless core within each of us" (p. 103). George's spirituality may be considered an inner reservoir from which knowing himself, his surroundings, and life's meanings emanate. It is a being that is continuously played out in relation to interpreting diabetes as an *unfolding life*. A life of spiritual quality unfolding is a life that experiences diabetes in profound ways, whereby meaningful interrelationships are created between an aboriginal diabetic self and the arrow of time.

Further, an aboriginal diabetic self is made up of connections between the thinking and emotional perceptions and actions of the human spirit, mind, and body. Experiencing diabetes is about living in the relationships between those connections. Couture (2000) explains that the threads of relationships are "revealed as the 'ground' to aboriginal being and becoming, and provides a sure footing, step at a time, for the necessary walk into and through contemporary dilemmas" (p. 158). George shared with me his spiritual ground of aboriginal being. Thus, his diabetic self is guided by a mindful spirit and body wherein relationships are foundational to being and becoming. And although the experience of living with diabetes is vastly different for each person, George's narratives reveal a diabetic self that emanates from his spirituality in ways that connect to an aboriginal way of being as understood, in part, within the dimension of time.

Cultural Time

> What is important to people in contexts of social and political situations [is] that [which] directly affects them. The relevance of what is being learned and why it is being learned becomes readily apparent, because it is connected to the cultural orientations as the people themselves perceive them. (Cajete, 1994, p. 49)

Time is critical toward enabling us to work through interpretations originating from an inner perspective that culminate in learning how to live a life. It is within cultural time that we discover over a *life time* connections to the intellect, the physical, and the spiritual without apology or expectation – a purpose in life. George, a sensitive learner, has come to acknowledge his cultural heritage whereby the wise teacher within him embraces what he knows and wants known by others. The path into what an aboriginal diabetic self knows and wants known was, for George and me, about uncovering his story or uncovering, as Couture (2000) states, "some of the underlying realities and processes that mold the topography of the traditional, aboriginal mind" (p. 157). George, like other aboriginal people living with diabetes, embodies these "realities and processes" that are still influenced significantly by "a timeless traditional reflection" (p. 158) taught to aboriginal children by their families. Thus,I have come to know an aboriginal diabetic self as told through *cultural stories* as George retrieved and reflected upon them as *life stories*.

As I listened to George speak I became attentive to how I was living, vicariously, in George's stories as we spent *deep time* together in dialogue. It was in the thinking about *conversational time* characterized by *cultural time* that I began to appreciate George's words of aboriginal traditions that manifest themselves as great principles – the honoring of spiritual awareness and development of values. How George perceived his own cultural orientations was given time to surface, slowly. Time and the encouragement to consider his feelings of prejudice, anger, empathy, misinformed interpretation, and injustice were necessary elements in our creation of authentic dialogue. This is so important in narrative inquiry – the means to a sustained and sustaining relationship.

Cultural time is about learning what the other values and believes in at an emotional and intellectual level, as well as at a deep spiritual level. George and I discovered that as we ventured back and forth between diabetes stories and life stories, a sense of *cultural spiritual time* compelled us toward an emotional posture that had few edges. We simply ventured through the genuine edges and boundaries of a complex aboriginal history of residential school and aboriginal-white relations to arrive at a commonality of true appreciation of aboriginal culture.

As I reflected for a long time between our conversations I was amazed that George was so deeply affected by our dialogue and conversations together. I was surprised that he talked about his experiences in *spiritual*, *storied*, and *personal* terms. Terms that are overlapping in the storied experience. This openness that characterized the conversations is what captured my attention and resulted in us being personally connected to the *lived research experience*. Thus, a space was created whereby we were able to articulate what George saw happening to himself in relation to the arrow of time.

Specifically, within the context of cultural time, we comfortably committed ourselves to a research process that established an emotionally safe environment for us to converse about the *eddies of life*. It is a metaphor that reminds me of the importance of life's fundamental ambiguity and mystery, thereby exposing the existence of depth to what it is that is being experienced and storied. It is in such conversing that we have an opportunity to orient ourselves to the phenomenon's meaning, as well as its resistance, in order to sense what it is in our lived experience that remains distinct to us, that holds meaning for us, and that edges us toward wanting fuller understanding of it (van Manen, 1997). George conversed easily at an intimate level and his candor assisted me to understand that during his life he had been accustomed to and encouraged by his parents and grandparents to share his thoughts and feelings because of how it facilitated his development as a human being.

Although the depth of our dialogue influenced by cultural time is difficult to contemplate, I believe that to some extent spirituality can be discovered within culturally competent research, as seen within this inquiry. If spirituality was expressed there, it can be expressed in other inquiries. The key point is that a culturally competent inquiry with aboriginal participants needs to be holistic and, as a researcher of narrative inquiry, I was willing to engage participants at a level of intimacy where *who they are* is more significant than the content of *what they say*. For George and me, the presence of spirituality unfolding within a context of cultural time was thought-provoking and respectful. It made this narrative inquiry culturally competent research, which existed because of an authentic, effective researcher-participant relationship we were creating together.

The shared moments of *lived life* as explicated through cultural time made George and I think of life milestones and how our relationships with family and friends are always changing. Such reflections drew me to the notion of being at home in the world. Gadamer (1989) emphasizes how being severed from a particular instance encased by a world of interconnections corresponds to a severance from understanding, a breakdown of our primordial unity of being at home in the world. It is a notion of being at home in the sense that somehow I already understood what George had shared with me. This intimate connection between understanding and being at home resonates in my heart. It provides a nuance to the meaning of understanding that brings as a companion not only a strong sense of familiarity of being at home, but also brings forth a newness to the process of understanding. Thus, if I understand something I am at home with it, and in being at home with it I understand it.

van Manen (1997) considers the notion of the risk of *self-loss*, the discovery of a different self following deep and sustained conversations, and the re-generation of meaning as consequential happenings through self-reflection. Within a narrative inquiry, this may be understood as a *shifted life story*. George is experiencing a *profound life*, but his experience of living with diabetes has not been totally visible. Making the not seen visible took us to the borders of his consciousness, and we attempted to uncover his original experience, the dark forest, the world of fire where nothing had been interpreted for him. As George shared stories of his early life and of the people who he had shared his past with, he emanated in his telling the *power of life*. He had reason to think about himself as a young boy growing up, fishing with his father-in-law, and having strong connections to certain people who made him feel *grounded* in living a life. George revealed his *fireman stories*, providing a glimpse into his *identity stories*. Such stories revealed an ethic that guided his humanness. It spoke, in part, to the colorful threads of George's life – a depth of existence to live by, to be transformed by, and to be remembered by - *a desirable life*. Thus, his aboriginal life stories came as an invitation to listen and re-listen to his aboriginal diabetic self stories. And they were narratives that left me with a deep sense of what it means for George to live a life even though received traditions of knowledge and wisdom, reflective of cultural time, are sometimes brutish and inert.

The Sugar Clock

> There could be no self-consciousness and human creativity without living organization, and there could be no such living dissipative systems unless the entropic stream followed its general irreversible course in time. (Arthur Peacock, *God and the New Biology*, In Coveney & Highfield, 1990, p. 220)

The arrow of time alludes to the arrow of a physical life – a diabetic life. A disorder of carbohydrate, protein, and fat metabolism cascades through a diabetic body as you read this sentence. A discrepancy between the amount of insulin required by the body and the amount of insulin available, waxing and waning. Somewhere inside the beta cells of the pancreas, the production of insulin and C-peptide proteins are unable to be stored with exact precision in the secretory granules of the beta cells (Sommers & Johnson, 1997). Its release into the bloodstream as blood glucose levels increase transgresses into biological chaos. And within this image of life, the sugar clock (Coveney & Highfield, 1990) of a diabetic body ticks unsteadily on.

The rhythms of the diabetic sugar clock vary dramatically, but they are indispensable to life. Insulin transports glucose and amino acids across the membranes of billions of body cells, with a propensity to target muscle and fat cells. It also increases the liver storage of glycogen, the chief carbohydrate storage material, and aids in the metabolism of triglycerides, nucleic acids, and proteins (Sommers & Johnson, 1997). Without the occurrence of such normal organization in the body and ensuing dynamics, the chaos of diabetes seems to occur, rearing up during episodes of hyperglycemia in the twinkling of an eye. Over periods of a few seconds, concentrations of biological substances can rise and fall within single cells. In the type 2 diabetes mellitus reaction, self-disorganization appears as whirling spirals of chemical activity where millions of cells adopt incoherent microscopic patterns of activity in space and time. Thus, lost in the diabetic body may be the necessary ordered phenomenon that establishes recovery from mild infections where normal glucose levels are discouraging to bacterial growth.

But life itself is an inherently highly circular process. The very genes that contain the blueprint for continuous feedback processes are responsible for regulating the way they themselves are recognized and interpreted in our bodies. It is not surprising, then, that while the cause of diabetes mellitus is unknown, genetic, autoimmune, viral, environmental, and socioeconomic factors have all been implicated in the development of the disorder. Indeed, the whole human body can be regarded as a complex phenomenon, a circular, self-organized system playing out processes in space and time.

George is not dependent on insulin. It is thought that with type 2 diabetes, his body exhibits the presence of some endogenous insulin, often associated with insulin resistance. In the experience of living with diabetes, George talked about how he came to recognize and appreciate, over time, the importance of remembering that there are essentially two different types of fluctuations that occur in the body. Good bodily fluctuations lead to good bodily feelings – such as taking his antiglycemic medication prior to eating a nutritionally balanced meal. Bad bodily fluctuations lead to bad bodily feelings – such as eating a cupcake as a snack between meals. As George explained what it was like over the past eight years to live with a diabetic body, whereby he began to understand and respond to the type of feedback his body was providing him, and later developing a deep respect for his body, I thought about how significant life was.

I began to think about the diabetic body as a producer of priceless chemicals in a reactor desperately trying to adequately produce or utilize insulin. For days I thought about George and his diabetic body as a thermostat attempting to control a central heating system. My image of the diabetic body was about thousands of glucose molecules in the bloodstream increasing rapidly by numbers like the temperature in a room. Once it rises to a set point, the central heating is switched off to cool it to the required level. Once this is reached, the heating switches on again. Invariably, George's antiglycemics will carry on lowering his glucose level after the medication is taken, causing a slight overshoot in lowered glucose level. Equally, when George's blood sugar starts to drop, the food George eats will cause his blood glucose to rise to slightly below the set *maximum* hyperglycemic point while more antiglycemic medication is starting up again.

In this way, as George explained how he felt as a diabetic, I began to listen deeper to the subtle meanings underlying his descriptions – the experiencing of rough and smooth cycles where blood glucose gently and abruptly rises, falls, and rises again and again. George talked about days where he felt inherently stable, experiencing a sense of being synchronized with the feedback processes inside his body. His experiences led to how he could play a crucial role in the response of his human body, for instance in controlling what he ate, how he exercised, and what caused stress. George, in relationship with his diabetic body, intimately knows from experience how the sugar clock plays an important role in the way his life varies in time, and he is acutely aware of how low sugars and high sugars operate together, for instance in the non-rhythmic production of insulin in a diabetic body.

Of course, alongside the sugar clock we discovered humbleness and respect. The same seemed to apply when we looked at another clock of life – the beating of the human heart. Although George experienced a heart attack and the onset of diabetes close together in terms of time, both were responsible for an array of important and often rather unpleasant effects. Bodily chaos seems to occur when organization in the body breaks down and is replaced by erratic rhythms. I speculate that George came to understand bodily chaos through his experiences of cardiac and metabolic disorder, which helped in the prediction of hyperglycemia and hypoglycemia through the analysis of activities derived from an unfamiliar body – *a diabetic body*. Significantly, George began to distinguish between chaos intrinsic to the body as a system and randomness caused by a cacophony of external influences. Thus, the hallmark of diabetic chaos is blurred vision, kidney problems, or changes in circulation and sensation to the extremities. Such alterations can be ameliorated or averted by a shift in bodily awareness, resulting from intuitiveness and personal knowledge.

Some elements of biological chaos are reversible and some are irreversible processes. Yet the irreversibility of diabetic chaos contains the map for chaos as well as for organization – just like the strength of nature, the soaring eagle, who sees from one eye a fire which destroys and in another a rainstorm that creates. In the course of our conversations together, George and I kept brushing up against these two facets of life, as we came to know more deeply and from a different angle that which told us we originate from the nature world – irreversible, dissipative, living bodies bound by the unidirectional condition of time.

Time at Play

> We are swallowed up only when we are willing for it to happen. (Sarraute, 1990, p. 55)

I have come to appreciate that play as a metaphor for life or experience is centrally important in philosophical hermeneutics (Gallagher, 1992). This philosophy suggests a view of play that is a kind of event, encounter, or movement that is without goals, that regenerates and reinvents itself, and in which people, if they are truly playing, become lost in time (Schwandt, 2001). Children play, naturally. During my conversations with George I found myself constantly returning to the notion of play. I thought about this phenomenon in terms of George's stories as well as my own life stories. The dimension of time provided us with entry points into the backwaters of our historical existence. We both began recalling and recollecting stories that we had not thought about for years.

George exhibited a playfulness in his personality which spilled over into his fascination with the world. I quickly realized that I had found a friend among my participants and George's *being* facilitated the circumstances for living and thinking at the same time. I became open to letting experimentation and creativity set the tone that might bring together the many spheres of our lives. Geertz (2000) points out that "Everything anyone says, everything anyone does, even the mere physical setting, has both to form the substance of one's personal existence and to be taken as grist for one's analytical mill" (p. 39). I slowly became attuned to the establishment of our conversational environment that required a caring flexibility that enabled me to recognize the moral perception that swept in and the scientific observation that flowed out. I thought of it as the devotion a seasoned islander gives to understanding the rhythms of tides.

It was in paying close attention to how my attitude toward a reality of research had combined my analytic self with my moral self that engaged with George's moral reality that gave me reason to pause. In recognizing his developing attachment to and interest in the study I began to wonder about the notion of play as the primacy of an event (Schwandt, 2001). A form of play that exists beyond the conscious reflection and control of the players. As I thought about recollecting the primacy of an event from the vestibules of time, my contemplation of this subject was far from being trivial. On the contrary, in Gadamer's (1989) philosophical hermeneutics I discovered that play is a dialogue of transcendence and appropriation. Thus critical to an understanding of an aboriginal diabetic self was the occurrence of play whereby a seriousness characterized our conversational encounters as events, not us as people at play. As my memory swept back and forth through years of temporality with the speed of light, and I considered moments in my life where I had been fascinated with the world and where I had lost myself in it, I began to look at George's life from a new angle. In terms of inquiring into an aboriginal diabetic self, I began to get glimpses into what it is that animates George's stories, what elements are there for understanding it, and what judgments I was placing on the values and facts emerging from it. It was only later that I could discern the realization of us being engaged in genuine conversations with one another.

For Gadamer (1989), play is an analogy for the event of understanding. Thus, George and I went back and forth between life stories and diabetic stories. We exposed ourselves to a milieu of moral vulnerability and risk. And we carefully, sensitively, held the emotional fabric of the content shared in those stories close to our hearts so that they remained protected.

George and I experienced a series of *play* encounters together – a disclosure taking place – where there was not only recognition of meaning but also a continuity of meaning across encounters. For instance, George's aboriginal self was further revealed to me through stories that brought to life his closeness with the spirit of an elder. I preface this explication with the words of John Barker who writes about Nuxalk traditions today in McIlwaith's (1948) book, *The Bella Coola Indians.* For between the spaces of our conversations, I was living in a historical past – an aboriginal past, and I pondered a deep reminiscence that arrived with the words, "The dismantling of the old house signaled the demise of the Nuxalk culture. McIlwraith did not doubt that he was witnessing the death throes of the Nuxalk and other First Nations cultures. 'Though the individual may suffer,' he wrote, 'civilization must press onward and the life of the Indian will soon disappear...A tithe of the people may survive, but their culture, the growth of generations, will have been swept away'" (vol. I, p. x1vi). In the same way those words gave me reason to pause, so did fragments of George's stories that told of a young man who fished with an elder in the valley. This elder, who was also his father-in-law, epitomized a meaningful friendship that was one of the most important and influencing relationships of his life. I listened to George talk about this Nuxalk man and his ways of being, framed by the well-timed humor of the elder's moral character. George spoke of his father-in-law's life stories and how they flooded into the moments and days they shared together. For George, the meaning of this man's spirit could be located in the happy memories George had of the valley he lived his life in. And George spoke of how this elder had told his stories through his spirit, the spirit of his body, and the truth that resided there. George shared with me stories about this man, who was close to his heart, and who had almost drowned.

George explained to me how a group of felled trees, known as a log jam, can get caught up in a river inlet. They are caches of wood that get swept up by fast running water that not only represent a tangled mess but pose potential danger for anything that comes close to them. During a fishing trip together, the boat that they were in capsized and his father-in-law was sucked under the water by the strong currents creating a vacuum beneath the logs. Fortunately, George was able to rescue him. Later as I reflected on George's story, I realized that a precious gift had exchanged hands, a gift that matched the elder's spirit. Thus, George and I experienced time at play - the disclosure, unfolding of meaning – in a way that resonated the true purpose of a relational journey. Such encounters have profound and lasting consequences. Their significance lies not in gifts received but in gifts given, causing in its wake an experience of transcendence and appropriation that changes a life forever. I too had stories of a guardian father who had profoundly changed the trajectory of my life. And, like George, I also had an experience that enabled me to direct the course of an encounter in a way that recognized the act of giving was the most valuable gift of all – the continuance of an influential life by the person who has come to love that human spirit like no other.

At the Fire Hall

my dad and I were in the car
heading somewhere
I felt small in our car, a 1956 Chevy
his hands
gently holding the steering wheel
we turned into the fire hall
an idea, it was a great idea
to slide down the fire pole
gold, shiny, exhilarating
I climbed the stairs
my legs wrapping around it
carefully, never touching my skin to it
then sliding, flying down
he was like that my dad
giving me carefree moments
playful moments
ones he knew I would remember
I paused to consider his work
there, at the fire hall
at burning places
his life as a fire man
helping others
seeing painful, suffering lives
It was dangerous work
he would tell me about the fires
how they started, his injuries
how people died, carelessly
I slid down the fire pole

his pole, visiting briefly
a place in his life
his past placed alongside mine
just me and my dad
playing memories across time

The Hospital

I was working the afternoon shift
dad was in the hospital
two floors above me
he had a recurring infection
tricky stuff
I got away early on my first break
he lay there in the dark
still
his meal tray untouched
I turned on the light
speaking
he was unresponsive
unconsciousness
he was breathing
I felt a weak pulse
I called the nurses
the doctor came
hypernatremia
sodium so high
no one knew why
a metabolic mystery
he went to intensive care
and recovered
I took him home

I think back to that time
  often
the ease in which life slips away
  my visit with him
our spirits conversing
  brought his body back to life again

Echo of the Past

> Patterns of the past echo in the present and resound through the future. (Ywahoo, 1990, p. 244)

As George shared his stories of an aboriginal diabetic self, we contemplated them like vignettes being played out as if we were in a movie. Such is awareness of the interpretative process that reveals something new in the present that at the same time reveals something old in the past. Perhaps this is an aspect of *resonance* – that condition or quality of being interconnected with a parallel source of being. Huber (2000) and Whelan (2000) write of *narrative interlappings* as we lay stories side by side. In revealing an aboriginal diabetic self, George could see in his mind's eye a self in the middle of a nested set of life stories – *old and new*. Although familiarity of aspects of an aboriginal diabetic self resides in specific diabetic stories and an awareness that those stories are set in time, the meaning inherent in parts of life stories is what George was experiencing. Fragments of stories with certain people that created patterns of a past echo - coalescing stories across the dimension of time. I realized that in the telling of these nested stories, clarity surfaced, assisting George to re-imagine new ways forward. Thus, George and I resided, together, in a temporal, storied flow of experience, discovering an aboriginal diabetic self.

An aboriginal diabetic self, as experienced and told by George, attempts to reach across his autobiographical storied boundaries. It is a fragile, tenuous, and unknown journey, because it is an exploration and composing and recomposing of self. The personal experiences that characterized George's diabetic self exposed his personal knowledge landscape through our conversations, which encouraged him to reflect on particular threads of his diabetic stories. This reflection brought him closer to a full reckoning of diabetes in his life. Thus, during our conversations, George and I talked about the possibility of that reckoning in a space that let him decide upon how a diabetic self, as an echo of the past, reverberated reconciliation, self-acceptance, and healing as an experience of the present.

The conversations that George and I experienced together called forward his relational stories. We explored his experiences as an aboriginal child growing up, as a person in significant relationships with others, and as an identity characterized by sensitivity, resilience, and honor. George recalled the emotional parts of his stories. For instance, he became wakeful to his own behaviors of *holding close* and *keeping at a distance* in relation to the people in his life (Coles, 1989). Together we conversed in those spaces that reflected something about the feelings that tend to accompany those personal distances, as well as how those distances shift in relationships across the continuum of time. It was a space where several narrative histories would come together – *an echo of the past* – that let us pause on relational remnants of the present. Gently, we considered the sensitive observations that originate from a gaze on intermingling narrative life threads.

Within the subtle details of Coles' (1989) work, he writes about how he settled into living and working alongside his patients as a resident psychologist. His experiences reminded me of my own nursing stories and those of other professionals in which the telling of medical histories is clearly prescribed, as opposed to the telling of medical histories as life stories. The tensions and conflicts that result from patients and professionals who are unable to tell their stories is a powerful and pervasive thought that resonates from the echo of my past. It is a prescription, sadly, that is still with us. George and I were experimenting with an approach to research that was revealing a gold mine of interpersonal understanding between us. As Clandinin and Connelly (2000) point out, George and I had "come to experience not only what can be seen and talked about directly but also the things not said and not done that shape the narrative structure of [our] observations and [our] talking" (p. 67-68). Thus, George and I were able to illuminate a reflexive relationship together, whereby we were living, telling, retelling, and reliving his aboriginal diabetic self.

Images of Time

> Lying, walking, sitting in this room, he felt himself ripening and coloring. (Le Sueur, 1990, p. 356).

George took me by the hand into the narratives of his everyday life – pieces of autobiographical, biographical, cultural, and collective impressions. We were journeying together through multiple story lines, crisscrossing back and forth over the gradient of time. I began to realize more deeply how socially constructed people are; how George and I were able to maneuver, gracefully, through the watching, listening, and telling of a story. Images of time within storied lines that were ripening and coloring him – *an appreciation of a coherent life*.

George had constructed his own stories about an aboriginal diabetic self. It was a construction of himself that was ripening in the living with a long-term, chronic illness. Within that construction were the various ways of knowing and doing, the creative responses, and adjustments that were a part of George's personal knowledge landscape. He had constructed a positive conceptualization of his identity, family, and community – a kind of counter narrative (hooks, 1989) to the dominant negative social narrative that sometimes shapes experience for aboriginal people.

Crites (1971) writes about the narrative quality of experience as a thesis that points to storytelling as one of the most important cultural expressions that exists, and that narrative is the formal quality of experience through time. He illuminates the narrative quality of experience through an understanding of sacred stories, mundane stories, and personal stories. Specifically, he claims that the personal story reveals the temporal form of experience. I like to think of the three-dimensional inquiry space of interaction, continuity, and situation (Clandinin & Connelly, 2000) in these terms, whereby all three dimensions intertwine, reflect, and affect each other in multi-faceted, complex ways. I find Crites' comparison of narrative as the formal quality of experience through time with that of a particular style of action, which creates something inherently musical through time, intriguing. The notion presents the idea that for music to be experienced as musical, it must be revealed in its entirety, wholeness - *its unity of form*. Thus a style emerges over time that is of a musical nature.

Crites (1971) helped me center my attention on the inner elements of an action of which style is a by-product, as in the movement of the body when it exhibits a ballet style or a jazz style. Through this kind of perceptiveness an action as observed in the movement of the body or in the rhythms of music may be understood to parallel the narrative quality of experience. As people take great satisfaction in the arts such as dance, music, and artistry, they take great delight in stories, because "it answers to a powerful if seldom noticed aspect of everything they do, of every gesture, every footstep, every utterance; answers to it and gives it a purified expression" (p. 293).

George delighted in telling his stories of an aboriginal diabetic self. Together we created a space that turned towards experience, where richness of expression came to life. Our time together was about the creation of a research story that was experienced on many levels. It was a narrative experience that took into account the experience of the participant and the researcher. By virtue of a human reality, our *reflexive temporal grasp* (Heidegger, 1962) applied itself to and was "manifested in the events we [experienced] themselves, and in the acts we [performed]" (Carr, 1986, p. 95). In attempting to understand experience through narrative, George and I stood together at the same point of reference – *the story* – a vantage point by which to view his diabetic life, his whole life. It was the continuity of life that made "us both participants in and surveyors of the temporal flow, both characters in and tellers of the stories constituted by it" (p. 95). As Clandinin and Connelly (2000) emphasize, narrative provides:

> ... a ground to stand on for imagining what experience is and for imagining how it might be studied and represented in researchers' texts. In this view, experience is the stories people live. People live stories, and in the telling of these stories, reaffirm them, modify them, and create new ones. Stories lived and told educate the self and others ... (p. xxxvi)

Thus, I had the privilege to observe and participate with George enacting a storied life, a deep self-educated life – a transcended life. Together we assisted each other to understand, shaping what was, ultimately, this research text, *An Aboriginal Diabetic Self: The Arrow of Time.*

I now turn from a way of being in time where "the self in its concreteness is indivisible, temporal, and whole, as it is revealed to be in the narrative quality of its experience. Neither disembodied minds nor mindless bodies can appear in stories. There the self is given whole, as an activity in time." (Crites, 1971, p. 309). Instead I turn to consider space which surrounds us like time, shaping and forming particular experiences and actions that inhabit *Aboriginal Experiences of Diabetes: The Representation of Place.*

CHAPTER FIVE

Aboriginal Experiences of Diabetes: A Sense of Place

In this chapter, the phenomena of aboriginal experiences of diabetes are revealed through the conversations I explored with Emilie, an aboriginal woman living with diabetes. Within the context of the narrative inquiry, a sense of place not only reveals a dimension in which situation makes Nuxalk People, the land, and the stories inseparable, but the concept further elucidates how aboriginal experiences of diabetes are embedded within the person's own life narratives of experience. It is the connection between certain stories and certain locations, resonant with significant meaning, that makes the narrative of an aboriginal life become visible. In building a trusting relationship with me, the researcher, Emilie simultaneously began to explore aboriginal experiences of diabetes, thus enabling her to empower her own interpretive abilities of the lived experience that considers *diabetic stories* as being a reflection of one's *life stories*. I begin this analysis with Emilie's narratives of experience *in living* with diabetes embedded in the retrospective cycles of her life narratives. In addition, I show that by turning to the notion of a lived research experience I continue to learn how to look at the world by continuously and reflectively being sensitive to every situation that poses the unremitting invitation to the creative activity of experiencing the world.

Under the Deep Blue Sky

This narrative of *Emilie's story* recounts, symbolically and in words, the continuation of a journey I made while researching and living in a place called Bella Coola. It is a sense of place where lived experiences have been described and interpreted over time. It is a world of multiple existences and realities, where each person residing there may be seen to explore and awaken to different curiosities, experientially and imaginatively, under the deep blue sky. It is about the diverse habitations within a perceived reality throughout the course of a day and across the span of a life that grounds us, profoundly, in the interconnected spatiality of our human existence.

Wild Mountain Goats

~

The Wonder of Sacred Places

As we gazed toward the high ridge of a sunlit mountain ahead of us, with red iron marking her breast and the forest alive with the breath of new air, I stood under the sky with Emilie, a member of the Nuxalk Nation. A mountain lion, which had been seen up the valley a few days earlier, had given us reason to talk. We turned our eyes to the soft brilliance of the sun. It was seen to highlight a particular crevice in the escarpment above, making everything close to it glow. Every spring wild mountain goats could be seen there. As if placed in a still photograph from a film, they would perch their lean and agile bodies precariously on the top of carefully chosen ledges, protected by the immortalized rock underneath them.

As I was consumed by the towering rise of such magnificent uplands, I considered the words I had read that morning on the location and environment of this historical place in McIlwraith's (1947) book, *The Bella Coola Indians.* It gave me reason to pause, to think about Emilie's people and the landscape and the stories; a place where mountain goats had long existed. The book had a way of capturing my imagination, resituating me in an historical place where mountain goats had been animals of great importance to the Nuxalk. And it precipitated me to consider how wool would have been woven into blankets and meat smoked as a staple in the houses during the cold months of winter.

Emilie turns to me, taking notice of the horizon and asking how the research is going. "Are you getting the people you need?" she inquires. I assure her that it is progressing well, thanking her for asking and wanting to participate in the work. "I am a 7
teacher, too," Emilie remarks. As her lips parted, slightly, into a sustained smile, I soaked up the facial radiance and humble pride that emanated from the poetic tranquility of such a presence, an honorable presence.

I began to learn how Emilie had generously contributed to the revival of culture during her life. Over the years she had taught the Nuxalk language in the community school, where Nuxalk shapes, forms, and a sense of place exemplify a proud cultural heritage. I learned how she invited others to bring traditional songs and dances into the lives of young students. And how she encouraged artisans to apply their crafts to cloth, wood, paper, canvas, and silver so that they could resituate long past Nuxalk ways into contemporary and new imaginative spaces. As I befriended Emilie, I thought about what it might have been like to be a person in this place - a Bella Coola cultural space. I thought of Emilie as running with the wolves, patiently inspiring, instructing, and empowering others. She was strong and passionate in nature, and I saw in her stories the unleashing amidst certain situations a subtle fusion of humor, creativity, and resilience. For when I looked at Emilie, I saw the landscape. She reminded me of the wilderness within us, that dark rich center which during our conversations had awakened thoughts of forgotten places. They were spaces where we remembered the importance of certain locations, recollected the significance of ancestral souls, and reminisced in the meaning of sacred places.

Somehow we deepened and expanded the content of Emilie's story. Those storied parts that bring forward a rediscovery of the impressions set aside in life. It is a recovery of feelings that are set in flight by the storied places unique to a substantial life. And it is a discovery of the awareness of forces residing there, provoking the kind of bodily sensations that well up beneath the skin to surprise us, deeply. I listened carefully to the way Emilie was telling her story. They were stories of a particular life as a storyteller and a teacher of culture. It was with a natural, instinctive mind, like a trail through the forest becoming thick with the undergrowth of new life, that Emilie's experiential knowledge was showing a new cultural way. Such were the creative fires that I discovered to be guiding her life and work among her people.

Later, as I looked out of the window of my winter home on Nukko Lake onto its snow-laden parts beyond, I imagined a she-wolf running toward me - a wonderful stirring. For it was by considering that knowledge is gained through spatiality as a direct, unmediated apprehension of the world that I began to understand a sense of place. Places located in aboriginal experiences of diabetes that were connected to the visual images of *situational stories*. And pictures of images that when spoken shape us like *sacred stories* – storied places of knowing (Clandinin & Connelly, 2000).

I Can't Do Anything

~

Acting Sick

"When I first found out I was diabetic, that I was sick, I acted sick. I wanted to act like I was sick. 'I can't do this! I can't do that!' That's the way I felt. The other thing was, why me? I can't remember my parents or my grandparents saying anything about diabetes. Nobody said they had diabetes." Emilie pauses. "There were a lot of things that I didn't want to do because I think I was trying to act sick. I was trying to get away with doing a lot of things because I was sick. Finally I met a person, he was one of my husband's fishermen friends and he was diabetic. And he told me, 'As long as you take your medication and don't forget to eat, you are just the same as I am. I'm still a fisherman,' he said. 'I can do all the things that I did before, so long as I keep taking my medication. There were a lot of things I had to quit doing because of being a diabetic,' he said. 'I had to cut down on my drinking and my smoking. And I had to try eating the right foods. I found that really hard when I was first diagnosed, being a diabetic, because we eat a lot of fish. And later on I guess, I learned to eat less and tried to eat more vegetables and fruits. And I had to quit bacon because I like my bacon,' he said."

"I remember back to about 1987 when I was first diagnosed with diabetes," Emilie continues. "I must have been quite sick before I was diagnosed, too. The reason why I went to see a doctor was because of my eyes. I couldn't see! I couldn't see enough to drive and read. And that really bothered me, because I was working in the school at the time. I was teaching our language to our children. I had a hard time. I think it was in 1988 when I finally took a year's leave of absence from the school. I didn't know what the matter was with me. It seemed like I just couldn't do anything right. I was nervous. And felt I couldn't drive."

"I finally went to see the doctor. I told him I wanted to see an eye specialist, because we had to have a referral from a doctor before we could see him. I told him, 'I can't read! I can't do anything! I am working in the school and when I try to check the children's work, I can't see.' And he said right away, 'Oh you must be diabetic'. And I told him, 'No way! Nobody in my family has ever been diabetic. I couldn't be diabetic.' I knew a little bit about diabetes, because I had seen a few people on the reserve with it. So he took all the tests. I was diabetic! He wanted me to see him, but I wouldn't go," Emilie explains.

"I waited a few days and finally went to see him," she continues. "He sat me down and said, 'You are going to bed here.' 'Why? I'm not sick. I'm not! I was sick when I came to see you before, but the only thing that is still bothering me are my eyes,' I said. 'No, you're coming into the hospital. I have to start you on some medication,' he insisted. So I said to him, 'Couldn't I go home and get a nightgown?' He said, 'Why do you have to go home and get a nightgown? The hospital is full of nightgowns!' I remember it was springtime, either March or April, and the ooligans were running. We were running! I was anxious to fry up all that fish."

"So I had to phone home and tell my husband I had to be in the hospital," Emilie explains. "But then they started teaching me. I found it really hard to change my ways right away, especially eating. I didn't like the food they fed me in the hospital. Everything was so tasteless. I have always liked to use salt. But they told me that I didn't have to fry the fish. I could bake it or even boil it. So that is when I stopped frying ooligans."

Cursed With Something

~

It Was in My Mind

"When I was diagnosed with diabetes I felt as if I was cursed with something really bad. I don't know why I felt that way. In my mind I couldn't believe that I was diabetic. But when I started taking the medicine, I started settling down. I spent about a week in the hospital and my body started to settle down. I was constantly nervous, twitching. My whole body was shaking all the time. I still have that shaking sometimes," Emilie reveals.

"But part of it was in my mind. I didn't want to take blood from my fingers! I just refused to do it! 'I can't do it!' I kept telling myself," Emilie continues. So every morning I walked over to the health clinic, which is about a block away from the house. I'd walk over there and make them check my blood for me, and go back home. At lunchtime I'd go back over there. I was doing this for about a week. I thought to myself, 'Oh, why am I doing this? I can't have somebody else looking after me all the time. I have to do it myself! So when my mind finally settled, I started taking my own blood count everyday," Emilie explains.

"I found it really hard to do it three times a day, just like my husband is doing right now. I do it once a day because it's stable. I know what makes my blood sugar go up, like ice cream," Emilie says, laughing. "Sometimes I just have to have ice cream or a chocolate bar. Then it goes up! But I learned to keep away from those sorts of things. But I felt so burdened! I acted like I was sick. And yet I wasn't sick, but I felt I should be. My mind was telling me I was sick. I couldn't drive because I had trouble with my eyes. I wanted to be *babied*, I guess. My daughter was really happy to be driving me everywhere

I went. And I thought, 'It's my car. Why do I have to go and get somebody else to drive my car? There's nothing wrong with me now.'"

"Once I settled down with the medication my eyes got better. I didn't even have to change my glasses. But I was so afraid of going blind. I took a year off from my job at the school because I thought it might have been the florescent lights," Emilie reveals. "On the reserve it was so bright in those rooms. I thought the lights were causing my poor eyesight. So I said I would just come back as a spare teacher. I didn't want to have the responsibility of being a full-time teacher. So they agreed. By then my husband was settling down with his drinking and we were spending more time together. We'd been married for a long time and it's easy to start drifting apart. The children were grown up and had left home. My younger son had just married. And I didn't have anyone else to look after. We didn't even have a dog or a cat!" Emilie says, chuckling. So, I wanted to spend more time with him. I quit my job and went fishing with him for about five years. I got to know him again. He then got too old to do it commercially and started having problems with his heart. So we retired together."

Afraid of the Disease

~

A Reflection of Ourselves in Others

"It really helped me when they sent me to the diabetic centre in Vancouver. I went by myself the first time and I couldn't really absorb everything. I think it was because I was still afraid of the disease and what it was I was experiencing. It was about a year later when I went back again that it opened my eyes to the older people who were there," Emilie reveals. "I remember meeting an elderly man. He seemed mad at the world. We thought, 'Is there anybody looking after him?' He was almost blind. This is what I really saw in the man. He ended up getting lost on the street. He had a white cane and a stranger stopped and asked him where he was going, because he had walked across the street and the lights hadn't changed! She took him back to his hotel across the road from the hospital. I thought, 'Oh my God! I'll get like that if I don't look after myself!'"

"I always remember the second time I went back to that centre because my sister came with me," she continues. "I was close to her. I was waiting to be examined by my doctor. I was sitting outside the meeting room and recognized one of our friends from a little village called, Klemtu. I went over and spoke to her. She said, 'Oh I came with my husband. He is diagnosed with diabetes and he is angry. He's in with one of the doctors right now.' We were still talking when he came out and he was mad. 'Nobody can tell me that I'm sick when I'm not sick,' he kept saying. 'I don't have diabetes!' He just stood there and I listened and watched. He was so furious!"

"He finally recognized me and came over. He said, 'They tell me I have diabetes but I don't. I do not have it!' He was denying it. And I said to him, 'I have diabetes. This is my second trip to the hospital here. I felt like you when I first was told, but I had to admit it.' He said, 'I'm not! He was still saying that when we left the hospital. A few years after they said he was clam digging. He fell and scraped his leg. They had to amputate up to his knee. Later they took his leg. And about three years ago he died. He just didn't accept that he was diabetic. And that really scared me because I had to go for a knee replacement operation. I was so afraid to have it done because I thought it wouldn't heal. But I did fine," she says proudly.

"After awhile living with the diabetes I got over the feeling that I didn't have a dirty sickness or something. When I made up my mind that I was not sick, took my medication, and did what I was supposed to do, I realized I could still be me and do the things I wanted to do. There are some things that I don't do like I did before, but I think I'm healthy enough now. And I got over the feeling of trying to make myself sick when I was not!" Emilie reveals. "I think to myself that I'm slowing down not because I'm diabetic, but because I'm getting older. I know people my age who just don't drive and go anywhere. But I go where I need to and do what I want to do. I enjoy life too much!"

Needing another Person's Help

~

Entangled Stories

"I've never had a diabetic coma or anything like that," Emilie indicates. "And I've never seen anybody go into a coma, but I've heard of it. It's scary. I've been lucky to remember to always have something sweet with me if I'm going to go away from the house for a while. But that is what I used to think a lot about. Once I went to Bella Bella to a potlatch and stayed with a friend of mine. I hated to ask her for something to eat when I needed it. You go to a little village where there's no café and it can be difficult. I finally told her that I had to be able to help myself in the kitchen and that I needed to make myself some toast sometimes. And I told her it might need to be a sandwich because my body starts to shake if I don't have anything to eat. And she said, 'Well sure! Help yourself.' I finally told her I was diabetic. I had such a hard time telling her. So I said to her, 'I should have gone to the store so that I can pack crackers and cheese around with me all the time.' I used to do this when I first became diabetic, but after a while I just didn't bother."

"I would realize that it was my own fault. It made me feel so awful. My body would start to tell me. It seems like such a simple thing to be able to tell people that I have diabetes and that I have to make adjustments. But I finally just told my friend," Emilie explains. "She said to me, 'I've known you for years. Why have you never told be you're diabetic?' I said to her, 'I just never thought of telling you.' But it was really because we lived so far apart, so it was good to spend a week together. After that she was aware of it. 'Here have something to eat,' she'd say. So then we would have some toast!" Emilie reveals, chuckling. "She became such a help to me, then. I felt that at least somebody was helping me. It made such a difference."

"When we went to the potlatch I had to be very selective with myself as to what I ate. I just couldn't eat everything. But I thought I wanted everything! That's why I don't like going. I'm an elder now but don't like to be treated like one because they fill my plate up with things I'm not supposed to eat. They usually ask the younger teenagers to do it. I ask them, 'Could I please go and get my own?' It is a difficult thing to waste food you know you can't eat. But my husband, he'll just eat anything that's given to him. That's what happened to him the other day when we were at a gathering. I saw three pieces of cake on his plate. He was sitting with his men friends and I was trying to make him look at me, but he just looked away. He knew! When we got home he took his blood count before supper. It was really high! I said to him, 'You have to be the one that looks after yourself. I tried to make eye contact with you so you wouldn't eat all that food on your plate, but you just gobbled it up! I wasn't going to get up and take it away from you with your friends there," Emilie retells, chuckling. "He then says to me, 'Well, it was given to me so I ate it!' But I hope he gets to understand."

Forgetting to Look After Myself

~

Looking After Someone Else More

"I remember when my mother was really sick," Emilie reveals. "She died about seven years ago. Two years before she died our family took turns looking after her. I was having trouble with my sugar count. I was going to Vancouver once a year to visit my doctor. I told him what was happening. He asks me, 'Why are your sugar counts going up and down?' he says. 'I don't know! It must be stress. I'm looking after Mom,' I told him. We had a hard time with her, because of the Alzheimer's. She even ran away in the middle of the night! Even if I slept in the same bed with her she disappeared. We were lucky she never fell down."

"And she would have hallucinations," Emilie explains. "That was stressful! My blood sugars finally stabilized once we got over what had happened to Mom. We looked after her until we had to bring her into the hospital. She was there for three months before she died. She just wasted away. I would think to myself, 'Mom could have lived longer if we hadn't put her in the hospital.' But the doctor told us that we were the ones breaking down, not her! She was ninety and it was a lot of work looking after her. We lived right with her at home the last two years. "It took me almost a year to get over losing her." Emile takes a moment to pause. "But I can talk about her now and think about the funny things she did."

"Just before she died, I remember the trouble I had with my blood count again," Emilie reveals. "It was like I forgot to look after myself. I was looking after someone else more. Mom was my focus for a long time. She would say to me, 'I'm tired. Don't cry over me when I go. Have a good life with your children. All your kids are ok!' That's life I guess. But it makes me think, too, that as long as I'm not under a lot of stress, it's what I do with my diet that's important. I'm not on a strict diet, but rather I eat a lot of vegetables. And rather than having fried meat, I bake or boil it. I guess that's the reason I'm able to control my blood sugars. I also think that I'm just lucky compared to some people I talk to."

Significant Changes

"I used to say to myself, 'Am I ever going to be happy after being sick? It's something like being angry at yourself and angry at your body. I often used to think, 'If I didn't have diabetes I'd be doing this or that. But why blame the diabetes? I'm over that now. I always say I live day by day and enjoy life as it comes. We're lucky we don't have anybody sick or destitute in the family. Everybody's healthy! I often hear my kids say, 'Oh Mom you're sick.' 'What do you mean I'm sick? There's nothing wrong with me,' I say back to them. The only thing that's wrong with me is that I'm getting older."

"About 15 years ago, many years after I was diagnosed with diabetes, there was a young lady who died of diabetes. Her situation scared me! She was on dialysis and died right here in our hospital. I used to think about her a lot," Emilie recalls. "It made me think how important it was to go to Vancouver for the diabetic workshops. They kept sending us once a year for about four days. I used to see a lot of people who had things drastically wrong with them. I remember one lady I met there. We went shopping and played bingo a few times together. She had been living in Vancouver for quite a few years before she moved back to her home. But at that time she was married and living there. I knew she was drinking every night. I made friends with her because I thought I'd learn a lot about diabetes from her, but she was struggling with some bad habits."

"I drank before I had diabetes, but not much," Emilie recollects. "The doctor told me that if I drank, maybe, I should quit because there's a lot of sugar in beer. At the time I smoked. So I quit drinking but I told him, 'I'm not going to quit smoking!' But I quit that, too. I just knew it wasn't good for me." My husband smoked for a long time, too, but we made our house smoke-free a long time ago."

"As long as diabetics take their medication and follow a diet, those are the changes that are important. At times I've tried to follow a diet, but when I had a family to look after and cook for I couldn't change their ways of eating. I might be able to now, since my husband is diabetic," Emilie explains. "I remember how my husband wouldn't use artificial sweeteners or diet pops the way I was using them. And I tried to find light cheese for us both. 'Oh, it just doesn't taste right,' he'd say. But he doesn't even know the difference now. I try not to let him see that it's light cheese or margarine. 'If you want it bad enough, you have to eat it. It doesn't matter that it doesn't taste as good as the real thing,' I say to him," Emilie reveals, laughing.

"Last Christmas I think I made the manager in the Co-op store kind of mad at me," Emilie chuckles. "I was teaching our language with students from the university. They wanted to become language teachers later on and were working in the school. We were getting ready for a party for the elders. Most of them were diabetic! So I went to the store looking for food we could give them to eat," Emilie explains. "I looked at all the cakes that everyone was bringing and decided to go buy some cheese and crackers. The store owner came over to me and says, 'What are you looking for?' I looked at him and said, 'I'm trying to find food to feed some elders who have diabetes. I can't buy anything here for them anymore'. 'Oh yes you can,' he replies. He went and got a jar of jam. I said to him, 'Have you ever tasted that jam? I bought a jar one time and it tastes horrible!" He laughs. "Well, he ordered more diabetic food and the next week we had new sugar-free candies and sugar-light juices on the shelves."

Smudging with Our Own Trees

~

Landscapes of Uncertain Situations

"I notice you're reading the book, *Bella Coola Indians*?" Emilie remarks. "There are many stories of our people in it. Since I was a little child some of those stories are like the ones that were told to us. We still tell our children them and they tell their children when certain situations come up. My grandparents are in those pictures," Emilie explains. "And my mother-in-law, Margaret. She received an honorary degree from the University of British Columbia. She was a great woman. She died in 1985. She came from Kimsquit and moved to Bella Coola in the early 1920's. In those days they were choosing their husbands and wives for them. She was one of them. She was so young then and chosen to marry Steven. Kimsquit is just over in the next channel. Nobody is living there now. There were a few lodges and logging camps there at one time. That's when they logged the whole valley out. The people there were wiped out at the time of smallpox. Those who survived moved to Bella Coola. I think it was around 1922."

"That is when the ethnographer, McIlwraith completed the study. There are many stories from the people in Kimsquit," Emilie continues. "They were too old to be out fishing or working in the canneries then. So they just stayed home and told lots of traditional stories. How that anthropologist did it I can't understand, because the people only spoke their own language. I remember them telling us stories about an animal. People call it the *sasquatch* now. We called it *sniniq'* in our language. *Sniniq'* was a big, hairy animal. Some people claim to have seen it in the valley here. Our family saw something, too, but we never made up our minds about what we really saw or what it could have been."

"It was about 1963. We were coming home from Anahim late at night. It was after midnight and my husband and I were with our oldest son. We had taken some people up the valley and were driving back," Emilie explains. "I was driving and about the forty mile mark we saw something. All of a sudden my husband started saying, 'Look, there's a grizzly bear walking across the road! It's a dark one by the road there.' So we were all looking hard at it. I said to him, 'That's not a grizzly bear. They are usually light haired. And I've seen the way grizzly bears and black bears walk, but this thing is walking like a human with long arms almost touching the ground.'"

"So we drove a bit faster to get closer to it. When we got near, it never looked back at us. It was big! It just kept walking really fast until it was off the road and into the bushes. And then it seemed to just disappear. We opened our windows and tried to look for it. I drove right to the edge of the road so that the lights were shining into the bushes. Did we really see it? We don't know. But the three of us saw something unusual. Our oldest son was fifteen years old at that time and he remembers it, too. We had heard this particular story so much that it was like a myth to us," Emilie recalls.

"It seemed like a young boy in the village met one across the river a few years ago," Emilie continues. "He said he was walking up a hill near the mountains and an animal was coming down toward him. He was duck hunting and bent down to tie his boots. When he stood up the animal was heading straight toward him. His body was just below the horizon of the hill. He said he got so startled by it and the animal by him! When he stood up he was looking directly into his eyes," Emilie explains.

"This young boy said it was hairy except for the black skin on his face," Emilie continues. "He didn't want to talk about it to many people, but he told my husband. He didn't even think about picking up his gun to protect himself. The animal walked away from him and hid behind a tree. He watched it go further into the woods until he couldn't see it anymore. That young fellow must have been about eighteen at the time. He's forty years old now."

"When he came to his senses he grabbed his gun and started running back down the hill," Emilie indicates. "There were three other boys who had been with him, two of them were my sister's boys. They had gone to check their traps and had got separated from him. They said that when they got back and saw him he looked really scared. After that sighting this boy said he couldn't sleep for days. My sister told me that it seemed like his eyes were sunken and every time he closed them he saw the face of the animal."

"We had to smudge him with our own trees," Emilie explains. "The smudging was with cedar, spruce, and hemlock used together. Sometimes if the mother of a child or a young man whose family needs it is willing to get it, we tell them exactly where to go to collect it. We use it with a wild root we pick in our mountains. That's what we use for smudging. We do the smudging outside with the whole family together. We pray to God, being thankful for letting the person live longer. Then we conduct a burning ceremony over the clothes they were wearing at the time the event happened to them. The root is then burned and we have a small feast," Emilie reveals.

"If somebody helps you, like when a young boy here in Bella Coola went through the ice and was pulled out, we give that person a gift. It usually depends on the person who was helped and their family as to what they want done," Emilie explains. "I remember when it happened to my son. I knitted buffalo vests with designs on them. We gave them to those who helped my son and his little girl. She must have been about five years old. They were on a four wheeler, went across the ice, and on the way back went through it. There were a few women skating on a rink by the river. They helped save them. They all took turns packing the little girl because she was soaking wet and cold. They went a long way to reach the car. We had a cleansing ceremony for them," Emilie continues. "After the accident my son said, 'I felt like I was carrying something that weighed fifty pounds on my back. I couldn't sleep.' After the smudging he said he felt a lot lighter. He was more at peace with himself."

Thimbleberry Bushes

~

Recollecting Childhood Places

"I was born and raised in Bella Coola in 1932," Emilie reveals. "Our village used to be across the river. A long time ago other tribes used to come to Bella Coola, so the Bella Coola Indians planted trees right around the flat lands. They planted gooseberry bushes and wild crab apple bushes, too. Everything that was thorny they planted. They called it a *live fence* because it was wide and thick. A person might have been able to find a way through it, but he never would have gotten back out unless he went through the gate. All the Bella Coola people who were protected by the fence never got conquered, not by the Haida people or the Bay people, not by anybody."

"One of my earliest memories was the big flood," Emilie continues. "It was around 1937 and I was going to school. The houses in the village were in one long row with a boardwalk in front of them. We lived on the upper end and one of my Grannies lived at the crossroads. The crossroad was at the school and I remember how I used to walk the sidewalk all the way to her house and then go on to school. I also remember all the animals that drowned and all the wood and lumber that drifted because of the flooding. The river had broken through a log jam just above the village and washed through all the houses. It had rained, snowed, and warmed up, bringing the river up. Everybody lost everything. And one of my brothers was born during that flood!"

"It was a different life, then. Every household had chickens for the eggs and different kinds of geese and ducks. Everybody had a garden, berries to pick, and lots of fruit trees. The other thing I remember was all the snow. It was five or six feet deep and we used to stand on the fence posts and jump into the snow," Emilie recalls, smiling. "But after the flood it got real cold so families stayed home. And just about every house got water inside. They said what hurt them the most was the water that went right into their cellars. The water damaged everything, including a lot of salted fish. Our people weren't canning much food, then. They salted their fish and meat. I remember eating a lot of salted food when I was young. We had to soak it for days before Mom would cook it," Emilie explains.

"They had no deep freezes in those days. I would help my Granny dry fruit in the sun all day during the summer. I remember picking thimble berries for her. I used to lay them on racks and she would make jam out of them. It was hot in the summertime and we would work outside. Once the fruit was dry we would tear a piece off and eat it. In the winter we would just put it in a bowl, add water, and there was delicious fruit. It was so simple."

The Change of Life Baby

~

Family Connections

"There were 12 children in our family, six boys and six girls. Two brothers and a sister were older then me. One brother died of a heart attack and the other got caught in the east wind in a boat on the ocean," Emilie reveals, pausing. "Mom and I were pregnant with her youngest and my second oldest son. We were pregnant together! And we almost had our babies at the same time, but Mom had him a month before I had my son. That was what they called *the change of life baby.* My brother and my son grew up like brothers. Everywhere they went they were always together!"

"I got married when I was 17," Emilie explains. "By the time I was 30 I had my last child. My husband was about seven years older than me. I met him while working at the cannery. It was across the inlet and I was 13 when I went there to get a job. I told the manager I was 16. Granny was living there and working in the cannery, too. She says to me, 'You're tall enough. You could say you are 16.' So that's what I did," Emilie reveals with a chuckle. My husband went to residential school and he would return in the summers. He just kept coming around to see me. Our marriage turned out alright."

"When I was young I wanted to go to residential school with my brothers but never did," Emilie continues. "Dad took us to live in an abandoned village like the one in South Bentinek, instead. You can still see the old village there today. They say our people who were living there and survived the diseases all moved to Bella Coola. But every winter we went there without my brothers to trap. My sisters and I didn't attend school until they started giving people a family allowance after the war. Before that we could have gone to school on the reserve to grade seven. But I only went about three months of the year, because we would go out at the end of October and come home in June the following year. We even spent Christmas and New Years out there."

"At times our whole family would be there, Mom and all my brothers and sisters," Emilie explains. My Granny would join us, too. We lived in the old houses that were left standing in the village. I don't know how many years we kept going back there, but Dad and the men who brought their families kept on trapping. We practically lived off the land. Now when I think about it, they were hiding us girls. They didn't want us to go to residential school. Both my parents went there. They were of the age where their parents would pick out their husbands and wives for them. Dad was a year older than Mom and she used to say, 'It is where we fell in love.' They were about 16. When they tried to force my Mom to marry a man that her parents picked for her she refused," Emilie continues. "Dad, too, refused to marry anyone else. They had gone to school and knew they could marry who they wanted."

"I remember the first year of the war. We had ration coupons," Emilie explains. "And I recall how most of the time we couldn't even afford the things they rationed out to us. There were just too many of us in the family and Dad didn't make much money. That's another reason why we were out trapping all the time. Or the men hand logging after trapping was over out in the inlet. That's why we didn't come home until around June. We would arrive back about two weeks before my brothers returned from school in Alert Bay. Mom would come home from camp for about two weeks before them. My brothers would spend the summer with us and then go back again to school in September. The rest of us would go back to trapping. I was lucky if I went to school for a month," Emilie explains, laughing.

"But I still learned how to read. I must have been about 12 when our family stayed home all winter and didn't go trapping," Emilie says. "It seemed like I had just finished grade seven. I must have done a lot of reading because I didn't have any problems with school. In those days after grade seven you just stayed home. So the people in our village brought an old building from across the river and we called it our high school. They got another teacher and she taught us grade eight. I think it was three years I took grade eight. The teacher used to say to me, 'Are you here again?'" Emilie explains, chuckling.

"But I wanted to go to school," Emilie reveals. "I even became a janitor and looked after the wood stove in the reserve school. It paid 15 dollars a month. We weren't allowed to go to the public school. There were schools all up and down the valley, but we just went to the residential school or the elementary school on the reserve. It was in the fifties that they finally built the elementary public school on the Bella Coola townsite.

But we used to have a hard time keeping teachers for the reserve school. A teacher would come in September and then leave at Christmas time. We had a union steamship that came in twice a week from Vancouver. It stopped here on Thursdays and continued on to Prince Rupert and then Stewart. On its way back down south it would stop in Bella Coola again on the Sunday. So it brought mail in on Thursday and picked freight up on Sunday. I remember it was like going on a cruise!"

Counting Fingers

~

Teaching Our Language

"I never worked during my lifetime while I was raising children," Emilie explains. "When my youngest son started school in the seventies I was so bored being home alone. My husband was out most of the time guide hunting. I recall when they were looking for ladies to tree plant. I planted trees during three seasons in the valley after they had logged out the area. Then in the late seventies I got to be one of the school counselors. They wanted to teach our language to the children in our school. I was offered the job and taught the kindergarten class. That was for 15 minutes a day, but it was a beginning. I began by counting in our language. I didn't know the alphabet, but I knew how to count. That's what we started with, just counting fingers, naming our fingers, parts of the body, and the names of animals and fish. I loved teaching those children our language. I just kept on going from there as a teacher."

"I remember when a linguist came to Bella Coola to write our language," Emilie continues. "He was from Holland and their language is similar to Bella Coola, a lot of guttural sounds. At the time I was working part-time in the school. The rest of the summer I worked in the cannery and mended my husband's fishing nets. The linguist came to talk to my mother-in-law. It was part of his university schoolwork and so he came to spend time in Bella Coola. He was a young man. I forget what his name was, but he started working with my mother-in-law. I used to listen to them and they would laugh! He was giving her the English word and she would give it to him in our language. Then he would write it down. I started to get more interested, because he was writing stories in our language. I listened to him and thought, 'If that white man can learn our language that easy and he can read and write it, I should go and learn that, too," Emilie explains.

"So instead of slaving over the hard work of mending nets I thought, 'Maybe if I learned how to read and write I could work in the school.' So that's what I did! Our band council hired this linguist after he finished school in Holland to write our language. And I went and learned how to read and write our language," Emilie explains, pronouncing the word in her language. "They call it an independent language. You see we have the Anahim people living a hundred miles up on the plateau. They speak a different language all together than us. They can speak their Carrier language right up to Prince George and understand each other. But there are only people from Bella Coola and three other villages, all together, who speak our language. If you go 80 miles out to Bella Bella they speak another language. People from Vancouver Island all the way up to Prince Rupert can understand each other. But in Bella Coola our language is known as an independent language."

"I went to many conferences when our students first started learning our language," Emilie continues. "I even went on my own when nobody would sponsor me. That's how interested I was. Up in Williams Lake there was another linguist. He was an Indian from Vancouver Island who was learning many of the native languages. I recall one time there were about a dozen of us or more sitting in a room. 'I can write any word in any Indian language in British Columbia,' he says. I was sitting beside him and listening. Then he says to me, 'We'll start with you, Emilie. Say hello to me and how are you.' So I said it." Emilie pronounces the words in her language. "He now had his hand up on the blackboard, but turned around and looked at me. 'Say it again,' he says. So I said it to him again. 'I can't write it!' he says. Emilie chuckles. "He was so surprised! That is why they say we are independent in our Bella Coola language," Emilie reveals. "They don't speak it in any other village."

"So I worked quite a few years in the school, but not only teaching our language. I worked on many traditional button blankets and aprons until I got sick! That is when I found out I had diabetes. I thought I was going blind and gave up this native artwork. They were always trying to get me to come back. I was finally able to teach last fall, because they were all adults. And they were people who I taught in school as children years earlier! It was quite nice," Emilie acknowledges.

"I realize it was easy for me to learn our language because our family had been with our grandparents who taught us how to speak it. But I never really used it after that because my husband and I just spoke English after we got married. The only time we used our language was if we didn't want the kids to hear what we were saying," Emilie remarks, laughing. "I remember being told that if we only spoke English, our children would learn faster in school. I think that was one of the reasons why we didn't speak our language to each other," Emilie reveals. "But it just came back. And it wasn't a written language until that young linguist came to Bella Coola. It was a verbal language, but I am able to teach how to read and write our language. We have a few elders who can speak it fluently, but they wanted to learn how to write and read it. So that was what I was doing."

"For the elders, they get frustrated," Emilie continues. "The only way I could really teach them was to read with them and they read with me. I kept telling them, 'You have to learn the alphabet!' We have an alphabet and it's completely different from English. The sounds look the same but are different. Like the *c* letter, you say *see* and with our language it's *hee*. It's totally different, so you have to learn the alphabet first. And there were a lot of words that were made up later. For instance, only the early natural animals in Bella Coola, Kimsquit, and South Bentinek have names in our language. They didn't have horses then. So when they first saw a horse they had to give it a name. This is what I always liked about the horse. A long time ago you had to pack everything on your back, like today with back packs. But to pack something on your back is *alhxapa*. When horses arrived in Bella Coola with the Norwegians, I believe, it became the animal that once packed people. It became *alhxapaliikw*, the horse that packs people. There were many words that needed to be made up later."

"Like book," Emilie continues. "I don't think they had books a long time ago, so they made a name for a book. But everything else has a word, like sky, stars, moon, sun, and trees. For instance, all the trees are identified as different trees, all the fish are identified as different fish, and so on with the animals. The word cat is another one. Our people had never seen a cat until the Norwegians came to Bella Coola and brought their pets. And a White man in our language is *qumsciwa*. So the White man's pet, the cat, is *qumsciwaalh*," she explains.

It Just Caught Up With Me

~

Figuring Out What Is Wrong

"Before I had a diagnosis of diabetes, I just didn't know what was wrong with me. I knew there was something amiss, but I didn't know what it was. I had a lot of things happen to me before I became diabetic, too. It was things like hernias and gallstones that set me back. I got a hernia because I was working at the cannery. That was really heavy work. I had to lift a lot of different things," Emilie explains. "And then I had appendicitis. I was sick all summer. It wasn't really painful, but it was there. We were going to go to Germany that summer. There were three of us and I was one of them. We had been fundraising all year and were going at the end of August. We had it all planned and I got sick."

"But before I realized I had diabetes I kept going to see the doctor,' Emilie continues. "I used to think that he didn't care. Then he finally told me that it was in my head, this pain that I had in my right side. He said, 'There's nothing wrong with you.' Finally I got really sick and my stomach just bloated out. That night I got so sick I went into the hospital about midnight. I couldn't stand the pain. Finally the doctor came in that morning to see me, but the weather was so bad they couldn't get a plane in to get me to the city. By the afternoon, the plane got me to Vancouver, but by then my appendix had ruptured they said," Emilie reveals.

"I was operated on down there and it took about four or five days for me *to come to.* He said he had a lot of *cleaning up* to do in my stomach and had to go right into my pancreas. He was worried about me and diabetes. He kept warning me, 'I have to watch you for at least five years. I'm worried that you might get diabetes from what I had to do, surgically.' So he told me to watch for different signs of diabetes. Then he said, 'If nothing happens to you in five years you'll be okay. You'll live to be an older lady.' So it always was on my mind that I might become diabetic through that. It was about nine years later I was diagnosed with diabetes," Emilie explains.

"Until then I kept myself busy all the time. It might have been because I did a lot of berry picking and mussel picking. I don't do it now, but we used to always be on the go all the time," she recalls. "I remember how over those nine years I liked to go fishing with my husband. We were busy all the time. If we weren't fishing we were working on nets. My doctor told me that the reason why I probably was sick for a couple of years before my diagnosis of diabetes was probably because I was so busy. It just caught up with me, starting with my poor eyesight and being thirsty. I was so dry. It caused me to drink water, pop, and whatever I could get my hands on all the time."

"But it was how my eyes were changing and being nervous that I really noticed," Emilie explains. "I was teaching in the brand new school that year and we went from teaching 17 children to 100 children, so I was really noticing how bad my eyes were. I kept saying to the doctor, 'Maybe I need new glasses?' I was in my early fifties, because I remember saying to Mom, 'I'm going to retire in this new school.' But I didn't want to go work anywhere else. And as much as I loved those kids, I ended up not going back. I decided I would spend more time with my husband, because he was alcohol free and had hired me on as his deckhand. I made more money working with him than I did by teaching at the school. Soon we started sharing everything. By the end of the fishing year, I got paid half of what we made and my husband got paid the other half. I felt good about that!" Emilie reveals, laughing.

"But I decided to go back to the school as a part-time teacher and fish in the summers," Emilie continues. "As long as I took my pills and was careful not to get colds or the flu, I was alright. I am much more careful with myself, now that I have diabetes. But I was always afraid of cutting my hands because of all the fish I cut. My doctor was always telling me to be careful and to not cut my hands, because the wound would have a very hard time healing. And it may not even heal. I didn't want to get fish poisoning, either! So I tried to be careful, but I did a lot of crazy things. I guess it was because I was going blind. When we were up in Prince Rupert one time I walked right in front of a car. I was almost run over. My husband was with me and he quickly pulled me back just in time. What was so strange to me was that I didn't see that car coming!"

"Not being able to drive a car very well was what really scared me," Emilie continues. "When my eyesight was still bad I continued to drive. I recall one time I was driving and I saw a car coming toward me and I started driving towards it, just like I was going to drive in front of it. I knew what I was doing, but I still did it. And then all of a sudden I just stepped on the brakes and got back on my side. They were blowing their horn at me. I pulled over to the side of the road to stop and sat there in the car for the longest time. I was going to get my daughter who was living up the valley then. When I got my nerve back I turned my car around and went home. I said to myself, 'I am not going to drive anymore until I find out what's wrong with me!' I phoned my daughter when I got home and told her, 'You're going to have to hitchhike. I am not driving anymore!' Then I went to the clinic and sat there until I could see a doctor. Those are the things I can remember doing, but I think it was because I couldn't see. It made me scared."

"So I spent a week in the hospital," Emilie reveals. "When I came home I had a hard time at the start. My sugar count was going up and down, and they told me I had to do a lot of walking. So I did a lot of walking and got it regulated. Now I'm just lazy to go walking, but I'm still doing fine. My sugar count never goes any higher than eight. But if I have ice cream or a piece of cake, it'll shoot right up! Or I might have trouble if I am taking some kind of medication, like cough drops. Then I'll get sick. Instead I will go to the clinic and get cough syrup that has no sugar in it. It tastes awful but it helps," Emilie replies, laughing. "I don't like to bother the doctors and nurses, but rather than trying to give myself medication it's better to come down to the hospital."

"I didn't expect to live this long," Emilie says, laughing. "I was saying that to the kids the other day. 'Oh, Grandma,' they said. 'You'll live another 50 years!' 'No way,' I said." Emilie chuckles. "But I guess I'm just one of the lucky ones who live long and healthy. And I'm not finished making vests with traditional Nuxalk designs on them, with buttons all over them. I made one for each of my sons, my husband, and some friends. This is my husband's vest, Sylvia." Emilie hands the garment to me to look at. "Oh it's absolutely lovely." I comment. "It is a black design with the white buttons being made of abalone or anything we can get a hold of. The abalone buttons are really expensive now," Emilie continues. "I make most of the boy's vests so that they are reversible. And I like to find material that has animals on it, especially eagles. I call it my black design. The young boys like it!"

Crazy for Ice Crean

~

Living in Diabetic Spaces

"I just live with diabetes as it is now and don't talk about it as much as I used to. Now I see my husband with diabetes. I keep trying to tell him that he has got to learn for himself," Emilie explains. "That is probably why I remembered a lot, because you came at the right time, Sylvia. He is 78 now, so it's hard for him to change his routines. I came home last night after I was with you. I went into the kitchen to get a glass of water and I said to him, 'You've been eating ice cream?' 'Oh yes, the grandkids were here. So I told them to make us some dessert,' he says." Emilie laughs. "And then he said, 'How did you know?' I said, 'Because I saw the empty pail in the sink.' 'Oh, we should have washed it and put it in the back. We never thought of it,' he says.

"I tend to look at food in a different way now," Emilie continues. "Like ice cream, we never had electricity until about 1956. We still had coal oil and gas lamps. Then I think it was 1956 when we got rid of all our old things and bought everything new, like electric stoves and deep freezes. So we were able to have ice cream whenever we wanted, which we didn't do before. I think we kind of went crazy for ice cream," Emilie explains.

"We used to buy frozen fruit from the store, but not ice cream. We couldn't keep frozen food, because there was no electricity. So when we first got electricity and our first freezer we went crazy. We quit canning. Everything was frozen at first, everything. But I slowly went back to canning because it keeps better. You can keep it longer than in the deep freeze," Emilie explains. "And I don't even like to use last summer's fish right away if it's frozen. I keep it for a year and then get busy trying to use it up. But I think canned salmon tastes better than when it is frozen."

"So I talk to my husband about diabetes and food and the things that I experienced when I was first diagnosed. I remember how at first I was given a lot of material to read on diabetes. I said, 'I can't see it.' But the doctors and nurses at the hospital just kept giving them to me to read. So I made a folder and brought them home," Emilie explains. "I recall how at two or three weeks after I was first diagnosed I was sent to Vancouver to see a diabetic doctor. He did everything. And I had my eyes checked. My heart was also bothering me and I remember him saying the reason was because I might have been sick for quite a few years before my eyes were affected. So I had to go through a lot of heart checks, too. "

"I had a hard time for awhile breathing and had to wear a nitroglycerin patch," Emilie explains. "I started off with a little white pill, because when they checked me on the walking machine I could hardly walk. And I would have heaviness in the upper part of my chest. So I made many trips to Vancouver to see a heart specialist, many more times compared to the diabetic doctor. It took a lot of visits every six months until they got the medication right. Now it doesn't bother me unless I'm not feeling well. They call it 'rumbling', because the heart sort of rumbles. I usually go to the doctor because of a hard time breathing with it,' Emilie reveals.

"But I remember how I started off with half a diabetes pill twice a day, one in the morning and one in the afternoon. That's when I was in the hospital and they were regulating me. So by the time I left I was taking one in the morning and one at night. I don't know how many years ago they increased it to two, but it's four a day now. It must have been about two or three years ago when they increased it. I recall my blood pressure going up, too. But so far I have been doing well. I don't take the heart patch anymore and take only a baby aspirin each day," Emilie explains.

"I told my husband just the other day how I used to have a hard time getting blood out of my fingers. When I first became diabetic, I had to squeeze and milk my finger. But now I realize if I do the glucometer prick on the side of the finger it's better, it comes out right away. If I try and put the needle right in the middle of my finger no blood seeps out. That's what I've been trying to teach my husband. He likes to put the needle right in the middle of his finger and he's got thick skin! It seems like he is having a hard time, but he is slowly getting better at it. He is starting to listen to me."

One of the Lucky Ones

~

Feeling Well Enough to Keep Busy

"When I first had diabetes they told me that I had been sick for a long time without any medication. And they thought, maybe, that it was because I was active, working all the time. That was why it didn't hit me so hard, not like what happened to my husband. It hit him so hard he almost died. He stopped breathing they said, because he was diabetic and not taking any medication for it. They had just started to test him for it," Emilie explains. "But with my husband, he couldn't drive, he couldn't see, and he couldn't read. He even had a hard time watching TV and slept most of the time. I kept asking him when he went to see the doctor to see that they checked for diabetes. But I never thought of checking his blood count myself, which I should have done, because I saw him drinking coke. He was never satisfied with one can. Every other day he would bring a box of coke home and drink it. He was always thirsty," Emilie explains.

"I went through the same thing. I kept asking him if they had checked him for diabetes, but he kept saying he didn't think so. 'They never told me that I'm diabetic,' he would say. Not until I started going with him, following him around in the hospital, did he find out, because he doesn't complain. I think I was like that too," Emilie reveals. "He didn't want them to find out he had diabetes. It's funny what we need to do. You think you're okay but you're not. But I consider myself one of the lucky ones. I've known a lot of people younger than me who have died of diabetes," Emilie remarks.

"It makes me think of those early years. I believed as long as I took my medications I would feel alright. And I used to think to myself that I'm not sick, so I'll keep on doing the things I want to do. My husband and I planted a garden with potatoes and things so that we didn't have to buy vegetables. We were just always busy. If it wasn't the garden work it was preparing fish, smoking fish for the family and ourselves, and berry picking. Sometimes I thought, 'I'm not going to bother with this work anymore. I'm just going to stay home.' But then I thought, 'I am losing out on everything that is going on. Why am I doing this to myself?'

"I thought to myself that maybe I wasn't true to myself or I felt it was a sin to be sick. Why me? Why did I get diabetes? Nobody in my family ever had it before. Why did it have to be me? What did I do wrong? I was blaming myself. This is what it was. I thought about our family going hunting and camping. And then pretty soon I didn't want to go. 'I'll stay home. You go with the boys. Go hunting and fishing. I'll stay home. I just don't feel well,' I would say to my husband. I know that was my excuse. But then I thought to myself, 'Well, I'm missing out on a lot of things that we used to do and I'm not sick.' There was no reason why I couldn't go, as long as I had food and my medication with me," Emilie explains.

"My sister helped me out a lot. She used to work in the hospital as a nurse's aide. She used to come over and say, 'Come on! Let's go for a walk. Come to the house. It's so nice out this evening.' She got me out of being depressed. Maybe, that's what it was, so I think she did a lot to help me out. She would say to me, 'The next time you have to go see a diabetic doctor, ask them if I can come with you. It's not that I want to watch you all the time. It's because I want to learn, maybe I will get it someday, too.' She is borderline diabetic now. But I realize a lot of it had to do with our weight," Emilie reveals.

"We're also not all Indian now. My grandfather was a half-breed. He was half Scottish on my father's side, and my grandmother on my mother's side was Italian. So we have a mixture of blood in us. We don't know if they had any diseases before us. At one time we were trying to track down my grandmother's brother in the United States. So far we haven't got anywhere, but my aunt did go to the States. They were trying to look around Seattle where she was born for some information. She and my mother were just babies when they were brought to Bella Coola, because their mother was dying of tuberculosis. So both my aunt and mother were raised in Bella Coola," Emilie explains.

"But we know our grandfather was definitely a Scotsman. My Dad had gray, gray eyes and curly light hair. None of us twelve kids had that," Emilie continues, with a chuckle. "I remember when one of my grandsons was born with gray eyes. He was my oldest son's boy. When he was first born he was looking at me, frowning. 'Oh!' I said. 'He's got Dad's gray eyes, the first one in the family to have them.' So I would think about our ancestry and diabetes. It helped me live with it. I quit feeling down. I remember, too, the doctor saying, 'If you don't look after yourself, you're going to end up having to give yourself needles everyday.' And I thought, 'Oh no! I'll prick my finger and use the glucometer. I'll accept that I'm diabetic.' But before that I had been forcing myself to do these diabetic things, and a lot of other daily things I used to always do. That is when I really accepted that I was a diabetic, when I realized I could still do the things I did before."

Changing Our Ways of Eating

"I remember how during my life we used to be out all day, berry picking in the mountains and in the valley. We'd go out at six in the morning to where they logged, and spend the whole day just picking berries," Emilie explains. "And then we would come home, clean the berries, and make jam the next day. I stopped doing this after I became diabetic because I thought there was sugar in everything I made. I was told that I just couldn't use sugar anymore. I had a hard time adjusting. I didn't like the taste of the artificial sweetener, but I got used to it after awhile. I don't preserve much fruit now. Instead, I freeze everything without sugar and add a sweetener when it thaws out. The thick jam we put on toast has half the amount of sugar the recipe calls for. So it doesn't affect me too much. Sometimes we buy marmalade or grape jelly from the store, but I find it so sweet compared to the ones I make."

"I've become aware of people with diabetes, like my aunt who lost her leg," Emilie continues. "And we have a friend who lost a toe, then an ankle and knee, right up to his thigh before he died. He was a very good friend of ours, but he didn't look after himself. I think the secret is to look after yourself and follow some sort of diet! You have to watch what you eat. I never really followed a prescribed diet, except that I just tried to eat less. And I ate more vegetables. Most of the sugar I have is from fruit, like apples and oranges. As a family, we used to have fruit with all our meals, because I canned so much. Every fruit that grew in Bella Coola we had, about 100 to 150 quarts a year. When the children were growing up we took the whole family and went berry picking. We bought our cherries from the people up the valley. And we would trade our picked berries for smoked fish with our friends. Now I just have fish and meats in the cold cellar, and hardly any fruit."

"We used to eat a lot more fish and wild deer meat in those days, too. We were able to get moose when they opened the road to Anahim. Before then there was none in the valley, so my husband used to hunt for deer all the time," Emilie explains. "We canned a lot of our meat because that was the only way we could keep it from spoiling. I didn't care for salted fish or salted meat. The only thing that was salted was ooligans and a little bit of salmon. In those days we hardly ate anything from the store, because we couldn't afford it. But we had a lot of our own wild deer meat. Now we buy our meat from the store."

"I don't think I cooked a turkey until the 1970's, because I didn't even know how to cook one," Emilie continues. "The bird was huge. Instead, we ate wild ducks, grouse, wild rabbits, and deer. We didn't eat much seal. We didn't like it. But we loved clams and crabs. I would can lots of clams. People used to go to Bella Bella in the fall to dig clams. We always had a variety of fish, clams, and meat to eat. And I remember the Bella Coola Bridge going across the river and all the old apple, cherry, and plum trees still growing in the old village. They attracted a lot of grouse and when our boys got to be old enough to use a shotgun, they were always over there after school hunting for grouse."

"We would make stews with lots of vegetables," Emilie explains. "The children didn't like vegetables much and that was a good way of getting them to eat them. And the meat went further than if I baked it. After we started to make money we started buying things from the store. When we were making more money from fishing and I was working, we started to buy different things from the store, like wieners. These things were new to us and it seemed like they were easy and quick to cook. Over the years our ways of eating changed. We bought canned pork and all sorts of things that we never really thought of buying before when we were so poor and broke."

Clover Roots and Solo Weeds

Rethinking What Is Good For Us

"I remember when we lived in the old villages near South Bentinek and how every other day we went down to the Pratt Flats to pick clover roots. Granny cooked them as our vegetable. It was a straight long root, and we would dig them up with a shovel. We also picked Solo Weed," Emilie recalls. "It was a thicker root and very tasty. She would cook it for us all the time. She added a little bit of sugar and ooligan grease to it. It was just like we were eating spaghetti because of the long roots. Granny would make a hole in the ground to store what she didn't cook. It was like a fridge, but in the ground instead. She was very particular about how she stored the food so that the dogs wouldn't go and dig it out. She would line that hole in the springtime with large skunk cabbage leaves."

"Years later I thought about how good this life was for us. I remember asking Mom, 'Did anybody in the family have diabetes before me?' She couldn't remember. But then, maybe, they didn't know about diabetes. A lot of people died young, then. Our people didn't go to the hospitals. They weren't allowed to unless they were really sick. And all the young mothers had their babies at home, unless they had a difficult childbirth. Mom had her first one in the hospital and the rest at home. So we just don't know if diabetes is in our family," Emilie explains.

"The only time I ever went to the hospital was to have a baby. I hardly ever got sick," Emilie continues. "Now we are rethinking what is good for us. I think that all this canned pop has a lot to do with diabetes. I used to go to the bingo hall just about every night. There were a lot of pop and chips eaten in that bingo hall. I knew I wasn't supposed to drink pop unless it was the diet kind. I had a diet pop once in a while and didn't care much for chips. But just about everybody had a can or two of pop in front of them and a bag of chips. And people would go around selling goodies, like cupcakes. It's no wonder people got sick."

"We didn't have bingo fifteen years ago in Bella Coola," Emilie continues. "When bingo started up I already had diabetes. I remember sitting across from my bingo partner who became diabetic after me. I said to her, 'Why are you eating potato chips?' She said, 'Because everybody else is.' I said, 'I'm not!' 'Maybe I can go and buy you a package of potato chips so I won't feel so guilty,' she said. I said, 'No thank you. Don't want any.' She is still having trouble with her diabetes. It's affecting her eyes. And she still hasn't really admitted to herself that she is diabetic. She is overweight, too. But it seemed funny when I said that to her. I still think it's important to tell people what not to do."

"But I love life! I still have lots of things I want to do in my life even though I'm older," Emilie remarks. "I remember our grandparents and how they all died in their forties or fifties when I was a little girl. I thought they were old, but now that I'm 71 I don't feel old. And I like traveling too much. We've always wanted to take an Alaskan cruise. But I wonder if we will ever learn enough about diabetes? I read anything I can get a hold of on diabetes. I keep suggesting we need a place for the elders on reserve to go so that we can share what we know about diabetes. We could combine it all together with our cultural events and our language."

"Our traditional dancing is coming back," Emilie explains. "I used to dance before I got arthritis in my knee. I used to do the ladies' dances. We would dance in between the men's masked dances. In our culture the women paved the way for the masked dancers. And in our language it has to do with cleaning the road in front of a masked dancer. It could be a thunderbird or an owl. The ladies danced to guard them, watching them in case they danced too close to the edge of the stage."

"This is the cape I made about 40 years ago. It is made of light material so as not to be heavy for dancing. My crest on it is a killer whale from my grandmother. I was told that my ancestors were whales. My husband's crest is an eagle. It is a design from one of the first eagles that came to Kimsquit. They go right to the beginning of time."

The wild roses smell wonderful today and on the petals the shadings have begun to soften, with pinks and whites seeping into the delicateness of spring. The rose bush was a perfect backdrop – a deep sense of ease radiates from her as the camera shutter clicks, so tangible it seems as if we were sinking into feathered pillows of enveloping space.

In what follows by way of Emilie's narratives, I examine place as situation and experience, as gestures of empathic imagining, as resonance of lived space, as becoming the space we are in, and as landscapes in transformation. They are stories that provided us with new explorations into the locations of Emilie's day-to-day existence and into the fundamental meaning dimensions of her aboriginal experiences of diabetes.

Situation and Experience

The notions of *situation* and *experience* make it possible to imagine diabetes not so much as creating a diabetic life, but as a part of it. It is to imagine context, culture, and location as explored places, whereby something is brought into being – experiences of diabetes shaped by an aboriginal life. More significantly, it is to contemplate new paths and old ways of Emilie's creation – places that have been influenced by an aboriginal teaching life, as well as an evolving diabetic life. By exploring a diabetic identity shaped by aboriginal language and culture, Emilie brought to life aspects of both her personal and social internal world – spaces of feelings, hopes, aesthetic reactions, and moral dispositions (Clandinin & Connelly, 2000). In addition, she brought to life aspects of her existential outer world – environmental spaces. And as revealed in the previous chapter, the direction of temporality - past, present, and future – is experienced simultaneously in these worlds also, positioning the experience of diabetic spaces more specifically in perceptions of reality.

I continue my analysis by considering the sense of place as a phenomenon through which Emilie's narratives may be understood as aboriginal experiences of diabetes. They are stories that guide the reader back and forth through the arrow of time to childhood spaces, married spaces, family spaces, teaching spaces, and elder spaces. As Emilie and I were continuously positioned temporally, we also stayed anchored to a place called Bella Coola, a space whereby culture is created and practiced, and where *stories of experience* are sorted according to a spectrum of cultural influence. Emilie's diabetic identity is shaped by aboriginal language, a rural environment, and supportive family and community connections. It is an identity that has to do with the ways in which Emilie considers herself as living with diabetes, as well as the images she has of herself being diabetic. We go inward to Emilie's perceptions of a life and outward to the experiences represented in her natural world. It is an existence that continues to challenge, as well as revivify, the emotional streams flowing through a semblance of integrity and wholeness.

Emilie is not alone in these enfolding spaces. These places enfold her and those she lives with, intensely and concretely. For aboriginal experiences of diabetes are also relational, as she reflects on particular people in certain locations, moving from an internal to external sense of place that originates from an experiential world. It is a world of relations that was opened up to us through multiple layers of conversation and dialogue. And it links a teaching life to subsequent experiences of diabetes, showing that Emilie came to be diabetic not as a novice, but with years of childhood, family, school, and formal teaching knowledge. Together such experiences are continuing to inform her ideas associated with being diabetic, which are enacted in the diabetic practices she chooses to make a part of her life.

As I attempted to be aware of the many narrative threads evident in *Emilie's stories*, narrative intersections began to emerge. As we were cast into a historical world of Nuxalk culture and the landscape through conversation, experiences of diabetes coalesced out of *certain locations* into *certain stories.* In recognizing that experiential phenomena are situated on moving ground, we focused, initially, on her feelings – a space characterized by *acting sick.* In a sense, it was a situation that compelled Emilie to experience diabetes in a particular way. It was also a place that provided her with an opportunity to tell how she *re-storied* her diabetes experience, by naming the phenomenon as an uncertain plateau within an internal world. Once named, the re-establishment of feelings within a certain location became recognized as expressions of significant knowledge, which resulted in a dramatic shifting of her perceptual position within a context of diabetes.

The perception of acting sick associated with not *feeling sick* as part of the experience of living with diabetes is best understood in terms of how Emilie framed it as a contextual reason for being. For example, Emilie positioned the idea of acting sick in the context of diabetes as a disease. As expected, a feature of disease is that it can make the person who is experiencing it act in severely compromised ways. As she repositioned her perceptions of living with diabetes from a view less oriented by thoughts of disease to a view more oriented by thoughts of wellness, hope became noticeably pervasive in her experience, while thoughts of despair soon disappeared. As I considered the array of reactions and dispositions associated with Emilie's experiences of diabetes, I understood the significance of needing to interpret the context of diabetes in multiple ways. For values and attitudes that are located in a view of diabetes as a context of wellness result in a set of health practices characterized by behaviors of wellbeing. Likewise, feelings that are located in a view of diabetes as a context of disease result in a set of health practices characterized by behaviors of being sick.

Amid many life experiences that may be perceived to dissolve together, Emilie shifted to a place whereby she did not want to *act* sick when she did not *feel* sick. Such a space became apparent as a result of the situations that were influencing a diabetic way of being. It was Emilie's self-determination that reverberated through the personal and social experiences of an existence, which were drawn from the early experiences of life, from an outdoor life, from a teaching life, and from an affirming community life. The inquiry sheds light on the importance of Emilie's personal and cultural knowledge, as well as a teaching landscape upon which her diabetic identity thrived. In effect, the complexity of the dimension of place nurtured a diabetic way of being that may have served as a guiding beacon for Emilie's diabetic existence. Such formations were integral to unraveling, albeit briefly, an understanding of the spaces of Emilie's shifting ground – aboriginal experiences of diabetes.

In many conversations, Emilie talked about her early childhood family experiences embedded in Nuxalk language and culture. As such, these early family situations existed as places for learning language and culture by which she recounts experiences that shaped the formation of an honorable aboriginal identity. As a language teacher, Emilie nostalgically recalls memories of speaking a Native language. They are thoughts that also reveal how her mother and grandmother had taught her to respect the land as if it were a gift, providing a bounty to the people who authentically connected with the continuous birth of it.

Each story about the sense of place makes valuable reference to the significance of Native language, of the landscape, and of traditional events that are central to the expressions of *family life*. While growing up, Emilie told of a *cohesive life* that was affirming in the eyes of others. She storied a place from which an *appreciative life* emerged, etched in the speaking of an ancient tongue and the performing of revered practices. It was by genuinely caring for others while mothering and teaching that Emilie contributed, profoundly, to a resurgence of ancestral pride. Such attentiveness to the continuity of cultural ways in the lives of others spilled over, naturally and unobtrusively, to the awakening and revival of an integrated *community life.* I believe that Emilie's identity formation was not only favorably nurtured in such a context, but was assertive enough to respond to the contemporary strains on cultural diversity inaugurated by technological and global influences, as well as multiple ways of knowing.

As a curious and mindful person, Emilie alluded to a meaningful educational life during her years as a child. It was commendable that she insisted upon returning to the same grade in school for three years, as a result of there being only one school teacher available in the village to teach. Later, she was dedicated to the development of Nuxalk language and culture, contributing to curriculum changes that reflected the significance of aboriginal world views and content. By bringing Nuxalk culture and language into the lives of others, Emilie enabled herself to use cultural knowledge in ways that connected her people to the wisdom of elders and to experiences of the past, with possibilities for the future. For her stories reveal a person who has undertaken, and continues to undertake, the personal commitment necessary to understand life in its deeper and subtle meanings – *aboriginal wisdom stories.*

The notion of respect permeated Emilie's stories. And it was by seeking wisdom to raise the kinds of questions which require thoughtful consideration that the discovery of answers has always been there, inhabiting the enduring themes of human contemplation, such as: How do I deal with diabetes – my own diabetes, that of my friends, my spouse, the people of Bella Coola? As a person who could envision an adequate life-paradigm, Emilie expressed a deep responsibility for the necessity to model a moral imperative to children, students, and people of the community. As a place for language, family, and culture to be lived and experienced, there were occasions when she viewed the community situations as being inconsistent and less than supportive toward an evolving diabetic identity. Through a deeper sense of the truth of things, Emilie empathized with the struggles of other diabetics as they experienced the happenings of an unprepared diabetic life. Not only was she perceptive of the challenges diabetes presented, but she learned to live in the present with hope of her own and collective preparedness. She valued the diabetic experiences of others, recognizing the tensions that surface when considering why bad things happen to good people and good things to bad people. For it was through a highly interpretive response to these kinds of questions, which Emilie demanded of herself, that the answers to a *healthy life* became visible.

There is a sense of indebtedness to other people living with diabetes from which Emilie drew, a drawing originating from the Wisdom tradition of a Nuxalk world. It is a world whereby she experiences an opening up of herself, holistically, to pathways suggestive of knowing how to live with diabetes. Emilie discovered through understanding what was required to *live well* in ways that had to do with cultural traditions, diabetic practices, and relations with self and others. Through her narratives I came to understand more deeply how aboriginal experiences of diabetes are reflective of highly experimental approaches, and the importance of diabetics and others partnering together to create an environment wherein our conventional understanding of diabetes can be re-thought, re-negotiated, and re-articulated. I came to realize how through the questions of a combined diabetes-life-practice that she asked of herself, arose her day-to-day sense-making in that practice. Such practices are fundamentally family-centered endeavors, which extend intricately into community-centered activities.

As further stories revealed, aboriginal experiences of diabetes involve giving back to the spiritual life of a place. Emilie exercised ways of increasing the attention of particular community members to specific diabetic situations. They included stories that provided examples of how Emilie shared her knowledge of living with diabetes in ways that led to changes for other diabetics, such as increasing the selection of diabetic food choices through the grocery store manager. And they included stories that encouraged others to consider implementing a diabetic way of eating while engaged in cultural gatherings and potlatches. As a person who has knowledge of and sustained practice in experiences of diabetes, Emilie has learned to pay attention to the day-to-day happenings and interdependence between perception and existence. As a result, her view has deepened, and she appreciates that there is a disparity between the way things appear to her and the way they actually are.

She has gained insight into the way her emotions respond to experiences of diabetes, and how she reacts to events of a diabetic nature. Underlying the strong emotional responses Emilie has to diabetic situations, she sees that although certain types of mindful states can be disconcertingly real, they are also always bearing teachings from one of the world's Wisdom traditions, whereby guidance from the meditative vestibules of her imagination and experience becomes commonplace to a diabetic existence. Thus, Emilie is able to view herself as a role model to other diabetics, providing guidance to those who aspire to manage diabetes effectively, as well as to those who struggle. It is situation and experience that shape a diabetic identity, entwine it with a teaching purpose, and ground it in Nuxalk ways of being – its sheer expansiveness enhancing her sensibilities.

Gestures of Empathic Imagining

In comprehending life in its deeper and more hidden meanings, the dimension of place is foundational to understanding aboriginal experiences of diabetes. The words of Ryga (1970) give me reason to pause:

> I will give you the wind and a sense of wonder at the child by the river, the reedy river. I will give you the sky wounded by thunder and a leaf on the river, the silver river. (p. 49)

For to consider place may take the form of a gesture that connects us to our sense of being, and to locations that exist within and between our humanness and the natural world. This act or perception of something located in our internal and external worlds is to consider the sense of place – the inseparability of people, land, and story, and how we directly experience them in our lives. During our conversations, Emilie and I contemplated the tangible distances between relationship and emotion that enable us to create *honored spaces of living*. Later I considered how these spaces are also silent, growing with every effort to know a life or a place apart from our own – gestures of empathic imagining (Neumann, 1997).

To contemplate gestures of empathic imagining as wise and important is to inquire into the evocation and substance of the universal nature of all knowledge itself. Neumann attempts to explain the nuance of these gestures when she writes:

> ...[that even] in the void of not-knowing, we nonetheless come to know, how even when we have no interpretation, we nonetheless construct one, gathering wisps of sight and sound that surround us into images that, through the weaving of interpretation, become real for us. (p. 96)

As I considered the tangible distances in the suspecting, as well as unsuspecting places of relationship, I realized how well Emilie had *storied* those personal connections between people and places. They were, in part, connections that brushed up against the immortalizing of an historic aboriginal landscape and the lives of its people. It was in these spaces that we were able to recognize the strength and resiliency that resounded in Emilie's ancestral life. For the enduring themes of a human preoccupation with an *ancestral life* permeated her diabetic life. Thus, we were able to recognize in her aboriginal experiences of diabetes the existence of ancestral connections to the mortal spaces of suffering, compassion, joy, and hope.

The inseparability of people, land, and story are partly narrative, partly silence, but extend beyond both into the realms of emotion and thought. Emilie's interpretations of the experiences of diabetes were influenced by her Nuxalk ancestry and cultural ways of perceiving. It is an influence from which she draws pearls of wisdom that tempers the challenges inherent in a diabetic life. It was there that I discovered in the cultural landscape of her diabetic life an understanding between the separation of diabetes as a disease narrative from diabetes as a disordered narrative. And it was in the separating out of something that was debilitating and tarnishing in its permanence to something which was disordering and confusing in its management that hidden meanings emerged. Emilie distinguished between diabetes as a notion of disease and diabetes as a notion of disorder.

It is a view of disease as an unhealthy, even *dirty*, condition in a person caused by bacteria or infection. And it is a view of disorder as an episodic, even *natural*, condition in a person caused by imbalance or chaos.

In the fragments and splinters of Emilie's early life narratives was the discovery of a fading but enduring traditional narrative that had contributed to a transformation in Emilie's *experiential stories* of diabetes. It was a transformation that had been guided by a plethora of aboriginal stories of healing and well-being. They were stories that had been told and retold to her by her people. Stories that Emilie had filtered through herself and that were now assisting her to make sense of her diabetic life story. And as we narrated her experiences of diabetes, they took shape as *enduring diabetic stories.* It is a powerful narrative that reveals how the experience of diabetes can be shifted from permanent debilitation to episodic instability and from despondency to clarity. Thus, they are narratives based on personal knowledge and experience originating from the sense of place in the lived spaces of Nuxalk culture. Places of restoration and renewal whereby diabetes stories are listened to and told.

As I was consumed by the poignancy of Neumann's (1997) words, I wondered what it is that continues to thrive in the telling of enduring stories. I would like to think that these kinds of narratives perpetuate an ethic of life through relationships that connect certain people to certain locations to certain stories. As I contemplated the sense of place as a construct of our internal and external world, a query related to *how* the telling of Emilie's experiences of diabetes was not only being shaped by *a life story* but was also being shaped by *a mythical story*, surfaced. It was mythical in the sense that imagined or fictitious thoughts, too, are aligned with a storied view of diabetes experiences, of which gestures of empathic imaginings are a part. I began to understand how multiple layers of a body of stories about diabetes, proven and unproven, are personified through time and space, and are entangled together. And they are multiple layers about the experiences of diabetes that extend beyond our normal human understanding or experience but, nevertheless, are located in a diabetes-paradigm. Neumann writes of these kinds of gestures as if they were neurons and dendrites. They:

> ...grew and joined, interweaving thought-from-right-now with thought-recalled-from-a-long-time-ago into thought-I-constructed-for-myself, perhaps not in pure fact, but in mind and in love and in wanting to know who she was, who I imagined

> she was, wanting to believe I knew her, wanting her image in my life right now. I chased after the ghost, and shells, and splinters of her stories.... (p. 95)

As I chased after Emilie's stories, I saw contained within them the cultural and personal knowledge that was part of her diabetic knowledge. As Emilie painted a storied picture of how she lived with her family amid images of the landscape, she revealed how it had affected her in harmoniously patterned ways. We ventured back and forth between emotional and relational spaces that had been born from the preserved strands of a Nuxalk heritage woven with the regenerating strands of a plant and animal world present in the valley for centuries.

I saw residing in Emilie's memories images recollecting a young mind, a place where seeds had been planted. They were seeds that had grown and flourished in an *attended* and *watered* place – a cared-for garden. It was a garden that reaped the harvest of a young woman's mind filled with thoughts, emotions, and imaginings. As she spoke of the connecting threads between different stories, she applied herself to a deep noticing of the situations which connected *family stories* to *marital stories* to *diabetic stories.* In the telling of her experiences of diabetes, she positioned and repositioned those stories. They were stories that had germinated from and were now reflections of significant *situational stories*. And they were narratives of the lives of others whom she had learned about, had been taught with, and from which an identity had been created. Ultimately, they were meaningful stories of complexity that Emilie was turning into *aboriginal stories of diabetes to live by.*

As I listened closely to how Emilie told of what was in her narratives, of how vulnerable we become when we *seek* help, of disrupting cultural stories, and of assimilation plot lines, she had grasped not just the map her ancestors had read but understood how they had made their maps. She identified with how they had made sense of their continually shifting landscapes of everyday-life in a world they had been cast in. And she spoke of the connections between how their lives had shaped her life, as well as the life she was living today. Emilie had discovered through *ancestral stories* a world further opened up, where bridges could be crossed away from the ramparts of defensive thinking and towards the freedom of new interpretations. Thus, she discovered in forgotten places a world of new understandings, of intricate aboriginal lives, and of diabetes experiences filled with wisdom and surprise.

It gave me reason to pause, and to think about the unfolding nature of diabetes as one strand of Emilie's life. And as with any life, to tell a life story is to peel away many life strands, uncovering what is vibrant, colorful, and visible. But it is also about not telling the whole story, to lay hidden in those strands the fine webs of meaning about other strands of the story, other strands of a life, a *fathomless life* (Neumann, 1997). Thus, I considered the deeper historical, cognitive, and ethical dimensions that exist in the telling of stories. They are stories that arrive not through just one door but through many, providing passage to new locations of unexplored phenomenological terrain.

The notion which Neumann puts forward of some stories being "less a story composed of the knowing that words can bring than a story constructed from the knowing that unworded feeling creates" is a significant one (p. 96). I considered, deeply, the stories that Emilie had told and realized that many had been left untold. Yet they were all stories anchored in a sense of place. Stories of aboriginal experiences of diabetes embedded in a life story that when told as narratives created a space for us to engage in the gestures of empathic imaginings. And they are gestures that helped us to catch glimpses of what is honorable, sacred, and wise in our lives – the song of our hearts and the music of our souls.

Resonance of Lived Space

> As I watch the brilliant bird, which looks as if it is made from smoke and compressed sunlight, the cascade of bird song falling from the canopy seems to grow louder. Vireos, thrushes, sparrows and wood warblers are all singing, their notes ringing off each other and spinning into space. (Hume, 1998, p. 60)

During my conversations with Emilie and contemplation of words written by others, I began to think about resonance, meaning, and harmony in relation to lived space. Connelly and Clandinin (1988) suggest that as stories come together they will interact and shape each other, whereby the personal knowledge inherent in the stories does not go untouched. As we sat sheltered in large armchairs in a living room warmed by the blaze of a wood burning stove, we drank tea while Emilie had many stories to tell. Each evening that followed I would reflect on them and be flooded with a sense of something beyond the contours of our usual imagination and experience. Together we seemed to recognize and respect the idea that telling stories necessitates the asking of life questions as if it was a practice. And it was a practice that necessitates our day-to-day ability to make sense of those kinds of questions as we ask them. We found ourselves in inquisitive and energetic spaces. Perhaps as women and teachers it enabled us to talk about our sensibilities, as well as the aesthetic reactions the narratives brought. As I situated her stories in an experience of research, I realized how her narratives had become known to her as *valid stories* – legitimized spaces of a living practice.

I believe that Emilie risked telling her diabetic-life stories because of how they resonated with meaning, which became visible through the lens of *a narrative gaze*. It is in such a *living space* that such structures abound, released by a proximity to each other that encourages us to tell our stories and by an internal responsiveness that provides us with the ability to share our thoughts (Conle, 1996). For Emilie it became another window to her inner self, to an interior world, and to a place from which to reflect from another angle. She could also return to the exterior world for respite, responding to the familiar *Bella Coola story* as a collective narrative. By moving back and forth between interior and exterior worlds, further connections would open up, providing a means to interweave deep *personal stories* with powerful *earth stories*.

Emilie's narratives precipitated me to think of the harmony that exists in my own lived space. How my inner being, for example, experiences tremendous renewal from living near water, recognizing that our home on Nukko Lake breathes harmony into the pinnacles of my soul. For it is in living by the lake and all the natural life that wells up with it that sets in motion a harmonizing effect on my emotions – spaces of aesthetic reactions. And such effects are long-lasting as I am reminded of the art and beauty in the natural world of Emilie's stories. Thus, I have come to appreciate more deeply an emotional dimension of the resonance of lived space (Conle, 1996), which exists in the act of *shared stories*.

The notion of shared stories is a significant one and it made me think that although Emilie and I are of different ancestries, emotional interaction has no boundaries. The words of Conle (1996) describe the unconditional nature of connecting emotionally that sharing experiential stories brings. She writes:

> ...it was the emotional interaction that helped us connect with one another's

> experiences. No two experiences that connected in this way were exactly alike, but the emotional connections seemed to be able to bridge differences and create similarities. (p. 305)

And so I considered our emotional connections as bringing to light wisps of clarity associated with understandings of harmony in our lives. Clarity that also had to do with recognizing the significance of the relations that were taken up between Emilie's telling of story, and the story that came about for me as a result of hearing it. Conle (1996) refers to this aesthetic creation as being derived from actions of fidelity in relationship to what is being heard, observed, and implicated. He writes:

> .... the relationship between the two stories is metaphorical. One set of narrative items is *like* the echoed other. The correspondences happen at a very personal level. Their connection is valid for a particular persona at a particular moment....emotion [playing] a key role in the connecting process. (p. 305)

Profoundly, emotions seep up into public spaces. The vulnerability and uncertainty that exists may be likened to the physical fear associated with having to, for instance, set out in a canoe across a large lake. At one particular moment the experience of leaving behind the shore on placid waters seems calm and pleasant. But at another moment the experience of being cast about with the lightness of a cork is terrifying. Such emotional thoughts bring gravity to the emotions elicited through stories. Thus, I realized that it is not possible to always know what the crossing will be like, let alone the treasures that await on the other side.

In terms of emotions, harmony, and treasures, Tafoya (1995), a traditional Native American storyteller and family therapist, reveals that stories go in circles, not in straight lines. He explains that if we listen in circles, then we begin to view the stories inside and between stories, and finding a way through them is as easy and as hard as finding your way home. He suggests that in order to find something of the interior world it is necessary to become lost. When we discover ourselves lost we begin to open up and listen – a pre-story space. It was when I identified with the *lost stories* in Emilie's *diabetic life stories* and in my *nursing life stories* that I became emotional. Thus, being sensitive to the circularity of such connections and associated depth of such relations reveals the *health and illness stories a life tells* – the resonance of lived space.

Becoming the Space We Are In

Story as a special kind of narrative opens up a different way of knowing, capturing the complexity, specificity, and interconnectedness of the phenomena of life. Carter (1993), in a discussion of what story is, as well as story as a mode of knowing, points to the narrative quality of our lives whereby the *personal story* or *teacher story* can be viewed as an important source of knowing. Emilie's personal story was, indeed, a teacher story. In addition, her formal and informal experiences in teaching the Nuxalk language to her people, were a reservoir of learning characterized by storytelling. Emilie innately knew that through storytelling life arrives at our doorstep in a story. And whether it is a brief story or a detailed one, it arrives and leaves again. For *becoming the space we are in* has to do with making sense of the events, characters, and settings that are arranged in a temporal sequence in our stories. It also has to do with perceiving in the *established stories* of a life the relevant implications of both causality and significance that influence the *becoming stories* of a life.

The nature of storied diabetic knowledge and claims concerning the centrality of a life story in lived space were important ones for both Emilie and me. Although her stories could be taken apart in terms of themes, characters, and incidents, as Carter (1993) points out, a whole story exemplifies "a distinctive mode of explanation characterized by an intrinsic multiplicity of meanings" (p. 6). In considering how easily Emilie's storied knowledge landscape captured the richness and the nuances of meaning in her experiences of diabetes, the stories also accommodated ambiguity and dilemma as narrative threads. As I listened to Emilie's specific life stories, it became easier for me to view her diabetic stories as a natural and common mode of thinking at the center of a constructive process. It was a process whereby "stories are especially useful devices for dealing with situation, conflict or obstacle, motive, and causality" (p. 6). As I thought, deeply, about her diabetic stories, I became more attentive to the importance of those stories encasing threads of moral dispositions. They became bobbins of colored threads reflective of an internal awareness of life – the depth of a life. For Emilie, *becoming the space we are in* was about the significance of storied diabetic knowledge, which revealed a moral sense and moral duty that characterizes a life worth aspiring to – *a compassionate and peaceful life*.

Moral dispositions derived from the challenges in life live as particular stories that move us in ways that allow us to perceive what is wise in ourselves and others – stories that have a life of their own. As I contemplated Emilie's teacher stories, I considered how applicable the central themes of moral and philosophical dispositions are to teachers, nurses, and mothers as *whole* enterprises. Both our lives have had to do with understanding the feelings, aspirations, and personal meanings that make us effective and fruitful in our particular enterprises, gently touching the lives of others. It is what enables certain people to be exceptionally attentive to the sensitivities of others. And it is what prevents the knowledge component from being separated from the relational component. Thus a storied view of experience exposes not only Emilie's practical diabetic-life knowledge, but her personal diabetic-life knowledge, revealing synergistically the extent by which she knows how to live a *moral life*.

In becoming the space we are in, I turn to Carr's (1986) notion of self and the coherence of life, which poses questions on how to live a *whole* life. He suggests that personal human existence, character, and personal identity are components of what may be referred to as the *unity of life* or *coherence of a life-story*. For instance, as I moved toward gaining an understanding of the course of Emilie's life, it was useful to consider the centrality of meaning in her life stories. Meaning that consisted of entities that she deemed valuable, which at the same time infused her life with purpose. In considering Dilthey's (1987) three categories of thought – value, purpose, and meaning - I thought about their significance in terms of Emilie's spatial standpoints and where each emerges. As Carr (1986) indicates:

> ... significance emerges primarily through memory, as in retrospect elements of the course of life stand out and make up a pattern...value corresponds to the present, and attaches positively and negatively to the realities of the world around us...and purpose belongs to the future as the projected realization of our values. (p. 76)

As I contemplated Emilie's stories, I thought about how the meaning of life has the capacity to order the things she values and how purpose sets in motion the development of a life. As much as temporality cannot be removed from meaning, neither can spatiality. For it is necessary to consider how meaning is framed and interpreted in patterns of space and time. As Carr suggests, to connect meaning and the development of a life is to consider "...its unfolding according to a pattern not imposed on it from above or outside but arising out of its own internal shaping (Gestaltung) of itself" (p. 77). As I pondered Emilie's own internal shaping and the *unity of life*, I thought about the patterns that were specifically arising out of a diabetic shaping. She had entered the inquiry field in the midst of living her story. Places in which she experienced *lived* diabetic order and disorder. And it was a location where she continued to teach and learn, as well as live in a community. Such multiple entry points provided the richness that made the joy in her stories noticeable. It revealed a new vantage point that highlighted a unity perspective, whereby the coherence and meaning of her diabetic narrative hung together with her life narrative. Thus, aboriginal experiences of diabetes were making sense in a dynamic and changing life story. It is a life story which encapsulates the sense of place in both interior and exterior worlds. And it is a life journey being expressed within the purview of the aboriginal meaning of a diabetic life.

Landscapes in Transformation

A sense of place captured in Emilie's stories is the representation of a Nuxalk ancestry made vibrant through connections to the landscape of the Bella Coola Valley. As I walked the streets of the township, there was more to observe than the physical objects of a modern school, a painted mural on the side of a building, a weathered crest pole with a slight lilt, or a river boat holding fish from the Bella Coola River. They were objects that elicited a mixture of thoughts – *memory boxes* (Clandinin & Connelly, 2000) of an historical place of people and events enveloped with the personal and social considerations of today. I pondered the scenario of the 2,750 people living in the valley today, of which approximately 1,100 people are of Nuxalk and aboriginal heritage. As Emilie explained to me, the Nuxalk are Salish-speaking Coastal People. And historically, thousands of years before the first Europeans came to North America, native peoples lived throughout the surrounding lands. It is a land that incorporated a vast network of trails, which crisscrossed the areas of Anahim Lake, Bella Coola, and Quesnel in British Columbia. It was portions of a route followed by Alexander Mackenzie in 1793 and named the *Alexander Mackenzie Route*, but is more accurately known as the *Nuxalk-Carrier Grease Trail*. They were trails built and maintained by generations of native people who lived with the land, traversing a trail system that infused life blood into a matrix of native cultures and economies (Birchwater, 1993).

In the introduction by John Barker in T.F. McIlwraith's (1948) book, *The Bella Coola Indians,* an anthropologist who first published a definitive ethnographic study of the Nuxalk Indians of British Columbia, wrote of that period:

> By 1922, the Nuxalk had been greatly affected by more than a century of interactions with Europeans. At the time of Mackenzie's visit in 1793, they occupied several autonomous villages dispersed along the Bella Coola Valley, the North and South Bentinck Arms, Dean Channel, and Kwatna Inlet. Smallpox and other introduced diseases devastated their population throughout the nineteenth century. The Hudson's Bay Company ran a post at Bella Coola from 1869 to 1882. In 1883, Chief Tom of Bella Coola invited a part-Tsimshian Methodist minister, William Pierce, to begin a mission to the Nuxalk (Pierce 1993:44). Meanwhile federal surveyors now reduced Nuxalk lands to small reserves. In the 1890's, a colony of Norwegian families settled at Hagensborg and the Bella Coola townsite (Kopas 1970). Over the years, the Nuxalk survivors gradually congregated on a reserve near the mouth of the Bella Coola River. The last of the outliers, the Kimsquit, moved to the reserve in 1922. By this time most of the Nuxalk were at least nominally Christian and many were employed seasonally in the local canneries and in logging. (p. xii, xiii)

Such an historical account gave me reason to pause, as Emilie described in her own words how she was born and raised by her family in Bella Coola. How she spent many childhood summers with her mother, father, and siblings picking berries in the mountains and fishing by the river. And how, in order to avoid residential schooling, her family would spend winters in different locations hidden and living traditionally off the hinterland. She explained how most Nuxalk people now live on the reserve adjacent to the Bella Coola town site or along the eastern border of the reserve adjacent to Thorson Creek, referred to as Four Mile, because it is located east of Bella Coola and along the highway.

Bella Coola is a magnificent place. It is a location that stimulated my imagination to feel lost in the richness of ancestral stories that Emilie humbly told. They were stories of invited glimpses into the lives of others whose existence continued to surface during our conversations as historical connections – resurrected life threads of significance. And they were those interconnected threads of stories that spoke of fragile traditional knowledge, teaching as a meeting place, and the practice of wisdom in contemporary forms. Such a field experience provided for an immediate contemplation of the universal nature of all knowledge, and the postmodern consideration for different ways of knowing. For in our dialogue existed fragments of other stories, strands of political narratives that contained splintered feelings alluding to the slow dismantling of a colonial stereotype of native peoples.

Emilie's stories provided me with a deeper understanding of particular personal, social, and cultural experiences – expressions that point to the significance of historical events and power relations between Natives, Whites, and the landscape. It is a risk that continues today – the destructive processes involving the environment, indigenous peoples, and social deformations that post-colonialism sometimes entail. As I considered the aboriginal landscape as part of a contemporary reality in Canada, I thought of the history that unfolded between European settlers, native peoples, and Africans - a complex interplay of three major cultural groups (Thomas, 1994). And I was reminded of Silko's (1996) writing, which exemplifies a dramatic counter-narrative juxtaposed with the elimination of the Indian rationalized as the extinction of a *different* people. For Emilie's story reminded me of the complexity associated with understanding European-Indian relations and the significance of colonization as an ecological event.

The historiography of aboriginal-white relations is deemed more understandable when Nuxalk life and the land are viewed as inseparable. Emilie's narratives are stories through which the identities of aboriginal people may be better understood. Her voice speaks of story and culture as a way of life, a freedom to live a truth, and a means from which wounds of past degradations heal. Specifically, Emilie reveals a diabetic-life that is better understood in the context of an historical place, its people, and their resilient and generous traits. Upon the completion of McIlwraith's book, *The Bella Coola Indians*, I was beset with mixed emotions. It was acknowledging how a particular way of life passes, like dust in the wind that was almost lost forever, that gave me reason to pause. And it was to consider the roots of change as the only constant, where the lives of past generations create identifiable threads that enable the lives of future generations to navigate the labyrinth of an uncertain and dynamic universe. For to be anchored in place and guided by time is to feel equipped with something greater than ourselves, as human conditions of disorder and death are experienced and faced.

It was with extreme interest that I was drawn to the concept of transformation as described in McIlwraith's ethnography, the *Bella Coola Indians.* They believed that uncontrolled transformational activity, which was described as being of the supernatural, was not only viewed as a state of chaos – disorder and confusion – but also as a state of unrealized potential. It was believed that a person who was unable to control such transformational activity would experience a state of imbalance filled with contradictions and dead-ends. McIlwraith also described the *Bella Coola Indians* as believing in the superimposition of order and balance upon which transformational powers brought life into the physical world. It was believed that the development of a life and the creation of a person within it, required the wisdom to order or control the powers of transformation, which resulted in the balancing of life events. It was thought that by balancing a state of sustained chaos at one end of the life spectrum the result would be absolute transformation – death of the body. It was also thought that by balancing a state of sustained stasis at the other end of the life spectrum the result would be absolute order – death of the soul. Neither state considered separately was thought to provide a person with a place to thrive. However, by believing a particular human state existed in between the two extremes, due to an unstructured force that was characterized by chaos, one could simultaneously consider a state of unlimited, perhaps unrealized, potential by which to respond to life's ordeals.

Historically, by observing prescribed rituals or ceremonies, order could be superimposed on the uncontrolled force that originated from the supernatural. It was understood as a transformational birth, which was associated with the person exhibiting disorder in life followed by order. As an extreme example, it was possible to consider how a person who had died was truly lost in the hearts and eyes of others, as well as consider the loss to be temporary. For instance, through ritual a stone could be taken from a cemetery and placed under the bed of a mother who had recently lost her child in hope of conceiving again. Such an act symbolized the provision of order - absorption of the destructive force of the supernatural in exchange for the superimposed force of order - which was believed to result in the stability of an event that had tremendous influence on the sensibilities of human existence. It was fascinating to think about an historical cosmological view of transformation in the past lives of the *Bella Coola Indians.* And to consider, perhaps, that some of Emilie's ability to establish stability in a diabetic life was drawn from the strength and perseverance of her ancestors – the wonder of historical life patterns permeating present day lives.

CHAPTER SIX

Diabetes as a Gateway to Aboriginal Healing: The Inclusion of Body

In this chapter, the notion of diabetes as a gateway to aboriginal healing is revealed through the conversations I explored with Violet, an aboriginal woman living with diabetes. Within the context of the narrative inquiry, the inclusion of body not only reveals a dimension in which a physical or bodily presence is both visible and concealed to ourselves and others, but the concept further elucidates the ways in which diabetes as a gateway to healing is embedded within the person's own life narratives of experience. In building a trusting relationship with me, the researcher, over time Violet simultaneously began to explore diabetes as a gateway to healing, thus enabling her to empower her own interpretive abilities of the lived experience that considers *diabetic stories* as being a reflection of one's *life stories.* I begin this analysis with Violet's narratives of experience *in living* with diabetes enveloped within the seasonal turns of her life narratives. In addition, I show that by considering the phenomenon of lived research experience I continue to learn how to reinterpret the world by taking up and rendering specific the meaning of the body. For a person is not simply a body, but through a physical reality is always materializing the possibilities a body brings forth. It is such possibilities that give active shape to the mundane way in which bodily appearances, expressions, and routines of various kinds are continually realized. Hence there is an agency which surfaces, as we inhabit our body in a thousand ways of being.

Wings of a Hummingbird

As a child I was impressed by the hummingbird, the rain falling on my face, and the fragrance of purple lilacs growing by the back stairs. For I believed it was during the spring that hummingbirds could draw a person to the light of a radiant afternoon. And it was in this shelter that my naked flesh felt caressed, unsuspectingly, by the wing of a tiny bird. As I lie on my back on the grassy floor, I wait for its body to dart and then hover. I anticipate its arrival. It is the lure of a clay pot appearing obtunded from blood red geraniums, spilling a brilliance of color that draws it near. I place my head to the ground and breathe softly, watching. It is then that the hummingbird feels a part of me, as if embodied in an awakened sense of physical being.

Violet drew me to the storied edges of a delicate life, as if we were hummingbirds weathering an uncertain storm. They are stories of becoming a mother, being a mother, and showing the consideration for the feelings of others in an experiential world. And they are significant stories ready to be told, connecting to the underbelly of a physical reality that diabetes beholds. For we pulled into the mortal threads a life bestows, the importance of motherhood, which for Violet and me contribute to a particular appreciation of life – *a special lived relation to another*. Such experiences gave Violet a reason to recall the relation of the lived body to its world, as in the early experiences of mothering that calls forth a primordial sense of security for a child. And it is there in later experiences of living with diabetes, that she embodies her motherhood by perceiving the world through motherly eyes. For they are eyes that continue to nourish the desire to be someone, to live for something, and to create the personal meaning that we crave in our lives someway.

In the experience of living with diabetes, Violet sensed a continuous unfolding of healing time in the modality of hope that she has come to cherish for her happiness. It is a presence that speaks to the world of its projected possibilities by setting things in relation to herself and her surroundings. And from the point of view of the lived body it epitomizes the experience of diabetes as a gateway to aboriginal healing. For she had many *intentional stories* to tell by which she organized and unified aspects of the experience of body as a diabetic being. They were stories of the healing body, where activities such as exercise and weight loss were focal points located within them. As I listened to Violet's *delicate stories*, they drew me to the early years of her life and to my own tender stories. And in unsuspecting ways we revisited a familial part of our world that was located in our separate and forgotten *childhood stories.*

In between our conversations, I considered the thoughts that surface in a story as if they were reflected images of an ancient river. They were pictures that focused my attention on the importance of traveling, side by side, with the refracted moving waters that also meander with time - *memories that live in our mind and our body*. For it is essential to recognize their recurrence within our shared life situations and to contemplate the history concealed there. Somewhere in the midst of my thoughts I felt it necessary to ponder a forgotten story, as if it was a recycled droplet falling from the sky as fresh rain.

It was a vignette that represented many stories of a young life that was shaped by the acts of others I did not always see. And in recalling it I touched the ice cold water of the river, looked at the steep carved curves of its riverbed, and listened to the unrelenting sounds that river rocks make beneath passing currents. For as we grow old and our bodies age, we do well to enter the winter season as polished stones. They are stones filled with memories of special days and times of the year that represent significant travel and celebrated events. And like a cairn on top of a mountain, our positive memories are housed in the location of our embodied souls that fuel the contributions we enact on the world. For through the snapshots of our existence is the guidance a life of thought makes transparent in our *childhood stories*, which live in our *adult stories* , and dwell as *significant stories* in ways that convince us that we are always bodily in the world.

As Violet shared her significant stories, they caused me to dwell on a fragile story of my own. For this is what happens when we are always physically in the world, our bodily presence leading us into conversations that later, when we take our thoughts inward, ease us into deep contemplation. I was about four years old when my mother and I left one home for another, leaving behind a father and grandmother. It marked a new phase in my life and my mother, aunt, and I settled into a small bungalow in a tranquil part of a new town. The year was 1960 and I can still recall the huge maple trees that had transformed the street into a magnificent, natural pathway. And although in the recollection of those memories they were some of my first and fondest, they were built on temporary ground. For my family, too, had their own particular struggles that are always a part of life. They loved me the best they could, but our situation together had changed in ways that were turning significant memories into fragile *mother and father memories.*

Family stories are as varied and novel as they come, always stretching the mind away from a view of conformity. In the realization that deep, under the surface stories are more likely to be messy and unconventional exists the immense complexity of mother and father connections. In this complexity were my lived experiences and perceptions as a child, and where I inhabited two stories of family that slowly merged into one. For aligned with my mother and aunt story came another family story that set me on a path toward a different existence and reality. It is a story of walking up the lane to a particular backyard where, often, I would visit with an older man in a flower and vegetable garden.

It was a serene place where plants grew in leaps and bounds. It was where an older woman served tea in cups of fine china on a tray with cold milk and homemade biscuits. Such was this everyday situation and relation that fed my mind and body with a fundamental sense of feeling at home. It was, for me, the making of a securer inner being that soothed the pit in a tightening stomach. These were two sensitive, wise people who showered me, generously, with kindness and affection that rendered this particular experience its quality of meaning. For I was a child who was contending with an edgy, weakened bodily presence and what they did for me always felt so comfortably settling.

The three of us would visit together, converse about things that mattered, and return the next day for more of the same. They were experiences that helped me to identify with a consciousness, moving and finding in life a physical reality discerned through thought as a sense of wellbeing. Such relational experiences made poignant *time* experiences, which made that backyard and garden significant *place* experiences. Through child's eyes I interpreted my mother and aunt story as fractured and unstable. It had begun to unravel. For an alcohol addiction was playing havoc with my mother's life and breast cancer was invading the reality of my aunt's. It caused me to live in the messiness of life where the emotions of love, sadness, and fear mixed with feelings of loss, grief, and despair.

But I was an observant child and I grew more perceptive. I was a child with a sensitive heart and in trying to close it I learned to live with it open. As I slid from one family to the other, a generous and compassionate existence took hold at a tender age of eight. It was a reality sketched with the bittersweet qualities from the life of a child that later, as an adult, I learned to interpret better. And in the knowing of gladness and sadness that permeates such fragile stories, I came to know them as universal human stories. For in these kinds of narratives I recognized adoration, and learned to love life and others in it. I was encouraged to be compassionate and inquired into the joys and tragedies that prevail in our lives. I was supported to question the nonsensical and ventured to make changes in the world around me. I was shown how to assist others, becoming empathetic and useful. I was treated with honesty and valued being truthful, especially to myself. And I experimented with a sense of humor by risking the giving of it away.

As I recollect this particular story, it connects with a reconstruction of all others. It is a story that keeps living in the tenuous folds of a physical life, for it is a *strong story*, linking me to the coherent threads of a prosperous life. And in its richness I continue to take steps to perpetuate its renewal - the continuance of a desirable life. Within Violet's shared conversations there, too, existed specific people whose significant stories made us both think of particular and familiar communities, the goodness and wellbeing that lies therein, and the meaning that is derived from our physical or bodily presence. It is there that we find aboriginal diabetic stories, whereby something is always revealed at the same time it is concealed.

Precarious Bodily Moments

~

Multiple Manifestations

"I recall looking after my mother when she was diabetic," Violet explains. "She had everything wrong with her. She had three discs that popped a certain way and her body just went way over. She was sore. I said to myself, 'Oh, I hope I'm not going to be a diabetic! I hope I don't get that.' And no sooner had I said that, I had it! I was certainly troubled over it, because I saw my mother and how she was when she was diabetic."

"Mom also had water under the skin that went around her heart and damaged it," Violet continues. "The doctors told us that it was damaged and that she didn't have long to live. She knew it, too. When it came close to getting real bad she was using a lot of pills under her tongue, but her heart just kept on going. She was feeling it, though! She used to tell me about it. She would say, 'I feel it now. I'm not going to be around long, not long'. One morning she phoned me. It was early and cold. She didn't want us to call the ambulance. She didn't want to go to the hospital. My brother and I put her into the car. He had to lift her from the wheel chair. We took her down to the hospital and right away they put her in emergency. They gave her oxygen but it wasn't helping now. She says to the doctor, 'I feel shortness in my breath, a real shortness.' They just tried to keep the oxygen on her."

"Our mother worked in the hospital for 20 years," Violet recalls. "It was while she was working there that she got diabetes. She must have been in her sixties. She retired when she was 65. She had been encouraged to work till then. They said it would help her to be active and to walk a lot. As soon as she retired from her job she seemed to go down hill. She got a lot worse, fast. Her face was all puffy. She was in and out of the hospital a lot for her heart. So with all that, came the diabetes. It all happened over a number of years."

"I was in my forties," Violet remembers. "Mom was on insulin needles. My brother gave the needles to her and her pills. He did most of the cooking for her, too. I helped with her needles and pills once in a while and cooked for her sometimes. She was able to stay home but went in and out of the hospital when she became ill. At times she was using the walker. I remember how she had lost so much weight."

"You see my father died just three years ago and he always used a lot of sugar in his coffee," Violet continues. "He would use at least two teaspoons, but he was also very active. I used to wonder if he was going to be diabetic because he used so much sugar. I thought he might, but he seemed to burn off all that sugar. He was alright all the way up to the time he had his stroke. It made him paralyzed. He had a really massive one. But my mother, her stroke was something else. They said that she had a stroke, though I'm not sure. I think she had a heart attack because her heart was affected a lot from the time she started having the diabetes. I feel that way sometimes, especially if I move too quickly to get up. Or if I turn around too quick, I feel dizzy. I say to my husband who is diabetic, too, 'If you do anything just take time on it. Don't rush it.' I know he's worse off than I am with his diabetes. So he understands now when I say that to him. 'Slow down, you've got all day today and all tomorrow and all next week,' I say that to other diabetics, too."

"But other than having to take my time, I feel okay," Violet explains. "I did find it hard a while back when I had a truck accident at the same time. The pain was really bad across my stomach. The intestine erupted. The seatbelt burst some of it! I had a hard time breathing." Violet chuckles a little as she recalls the accident. "It didn't take much. I tried to step on the brakes but I stepped on the gas pedal instead and went into the concrete. I said to myself, 'Oh, what happened?' But I recovered and we got the truck fixed," she says with another chuckle.

Tricky Stuff

~

Knowing What Not To Do

"Just about my whole mother's side from Bella Bella has diabetes," Violet reveals. "Her brother had it really bad and my youngest brother is like that, too. There is a lot of arthritis in the family as well. Their fingers are all crooked. I remember the doctor phoning me one day to ask about all the diabetes and arthritis in our family. He wondered where it was all coming from. He asks me, 'Who are your relatives?' I told him and he knew them all."

"I don't remember exactly when I was told I had diabetes. You see it's about 11 years now that my Mom passed away," Violet says. "That's how I remember how long I've had it. It all happened around the same time. It was hard. But I have an uncle on my mother's side who is not a diabetic. His wife's not diabetic. And on my father's side of the family they are not diabetic. It is my mother's side that is really diabetic. Two of my brothers are diabetic right now and one of them comes to me with his pain. I know what the pain is. It is where the pancreas is. I say to him, 'What you are doing right now is not helping any. You're going to have to take care of any drinking you're doing! You're going to have to quit it.' And he's mad about it because he doesn't like what I have to say. And I say to him, 'That attitude doesn't help any. We all wonder why we feel sick. I'm 65 now. I feel ailments all over. You're younger than I am. You look healthy yet, but that drinking is getting a hold on you.' I have to talk like that to him because there is nothing anyone can do about it except him. We have to make our decisions based on what we are doing and what we are not doing."

"I remember when there used to be candy on the table," Violet continues. "I would eat it all, but that doesn't happen now. It would just make matters worse. I know what will make my sugar high, and what I have to do so that it can work its way down. I remember how a diabetic I knew was always getting blisters on his toes. He already had several toes off. He just had a lot of difficulty with his shoes. When they fixed him up with special insoles he just fell in love with them. And then when my husband's toenails needed cutting, I'd go with him because he wouldn't go in by himself. I asked the health nurse, 'Can you cut his toenails? I don't trust myself.' She said, 'Sure, come on down.' She kind of gave us the day. He really liked that because he was having a hard time with his blood pressure, too. His diabetes hasn't been too bad lately. He has a sore toe, though. It's the callus that's causing it. It's really thick so the doctor just keeps slicing it off next to the skin because underneath it, it is infected. So we've been going to the clinic twice a week so that the nurse can look after it and watch it."

"My husband told me he didn't want to lose another toe," Violet reveals. "He feels there is already a big enough difference in the balance between his two legs," she explains. "He says that to get on his fishing boat he has to step on the edge of a big gang plank, and that he can't do it with the leg that is missing a toe. So he doesn't want to lose another toe. It's tricky stuff."

Too Much Itchiness

~

***Changing Our* Ways**

"Before I was diagnosed with diabetes I remember how much I itched everywhere. One time I had a rash on my knee and I couldn't figure out why I was so itchy there," Violet explains, gently smoothing her hand across her knee. "Now I realize that the diabetes had already started, but I didn't go to the doctor right away until the knee was really sore. It was just really itchy all the time. The diabetes is what caused it! And inside my eyes, they were itchy, too. I couldn't seem to find the itchiness. I would use a tissue and try to get at it. But it just got itchier until the diabetes was corrected. Then the itchiness stopped."

"I would have pain here, too" Violet continues, pointing to her abdomen. "I didn't know why there was a pain there. That is when they gave me some blood tests. After they told me I was diabetic. I remember how my back got sore from the kidneys. It was from my blood sugar levels being too high. They were really high then. That's when I felt the worst. It would hit my eyes first. It was down in behind both eyes. That is the way the diabetes affected me. I remember how the sun was so bright and the television too bright. I couldn't watch television or read. My eyes just hurt. They were so sensitive. I finally went to see the eye specialist. I went back twice a year for a while and then once every year. They wanted to see if my vision was going to get worse. Fortunately, my eyes never changed."

"It was hard to believe I had diabetes," Violet remarks. "It sure drained my body. It seemed like I had no energy. Before the diabetes I had lots, but with the diabetes I didn't even have the energy to walk. It seems like a long time since I was first told. In other ways it doesn't seem that long. When I first went to the hospital for the diabetes I felt differently about myself. I could feel it in my eyes. It made me think to myself, 'I'm going to go blind. I have to get my eyes checked.' And then I had headaches for over a year. Later I learned that high blood sugars can cause headaches. The other night I had a piece of cake. It was given to us because there was a celebration. After I ate it my body started to itch. I was telling my husband and he said, 'No, don't eat it!' But I had made up my mind to have it because it was just sitting there. I wasn't there when they placed it on the table. After I ate it my whole body started to itch. It was just as if something was crawling on my back. I scratched and scratched!"

"I remember one fellow who died from diabetes," Violet recalls. "He was younger than me and had really thick, dry skin from scratching so much. His skin looked so rough and sore, but he just kept scratching! Before he died I saw him. He was in the hallway of the hospital and I said to my husband, 'He must eat too much chocolate or something. He must get somebody to buy it for him.' But I know what it's like to have your blood flowing with sugar, because you crave it. His skin looked so red! I felt really bad for him. 'You see what you're going to get if you start?' I said to my husband. He used to just love his chocolate! He looked at this man. And he must have thought about it because now I see him eat it just once in awhile."

"I was thinking about this the other day, because we were talking about my grandson, the one who likes chocolate, too," Violet continues. "The other day I was teasing him about eating so much of it. I say, 'Grandson, you're going to get sick with this.' He looks at me and says, 'What am I going to get if I get sick?' 'Well,' I say, 'I can't eat those kinds of sweets because I'm diabetic now. Papa is diabetic, too.' He asks, 'What's diabetic?' It was good he was questioning me. So I was telling him about it. 'You see why Papa lost his toe?' I ask him. He looks at me! I notice now how he doesn't seem to be eating as much chocolate."

"So he knows why his grandfather lost his toe, partly because he ate too much chocolate," Violet explains. "He says to his Papa, 'What kind of chocolate do you like?' Violet laughs. "I remember how I used to keep large candies around the house, but I wasn't much into candies. I would eat some if somebody gave them to me, but I wasn't much for it. But the pop, that is another story. I never drank so much pop as I did before I knew I was diabetic. That sure helped boost the diabetes up! And I was overweight, so my chances were even greater for being diabetic. Some people I know are three hundred pounds. I say to them, 'If you don't start walking you'll be a diabetic sooner than later.' I got as big as they did, but then lost weight when I found out I had diabetes. It's hard to be really heavy. I say to people, 'If you keep walking you might not get it. Don't drive your big nice truck everywhere, keep active. Don't eat so much candy, chocolate, and potato chips. Don't take so much of it! And at the dinner table don't eat so much.' I know I sound bossy but I have to say it," Violet remarks, smiling.

I Quit Baking Pies

~

Diabetes in the Family

"I take pills for my diabetes," Violet comments. "I've never had to go on insulin. But the health people said that if ever my blood sugars wouldn't go down, that I'd have to make it come down. I'd have to go on needles to bring it down. And I don't like needles!" Violet pauses, considering her thoughts carefully. "It took me awhile to accept that I had diabetes. I sure didn't like it! I not only had diabetes but I remember my youngest son dying of liver cancer at the same time," Violet explains. "He had a lot of complications with it. The acid was going into his stomach and he was bleeding. He was in the hospital more than he was out. I was so worried about him."

"My other brother was told he had diabetes, too," Violet continues. "He didn't like that news. He kept saying, 'I'm going to die! I'm going die!' I've got six brothers and no sisters. Two of my brothers are diabetic. The one brother who we thought we were going to lose three years ago seems to be doing a lot better than he has ever done. He seems to know when he has had too much of something. He is in much better control of the diabetes now. I'd say to him, 'don't drink anything that is going to bring your blood sugar up!' He used to get mad at me, too, because I talked to him like that. And I'd say, 'I know what I'm talking about. I'm diabetic, too. If I drink pop that is not diabetic I end up with pain, headaches, and a sore back. Do you know why?' I asked him. 'It's because my kidneys are working twice as hard. And my pancreas and liver are working twice as hard.' I said that to him again and again. Now I think he finally understands what I'm going through."

"I think he's cut down on a lot of things he used to eat. And he seems to be keeping active as well," Violet explains. "I remember how he used to have to stay in bed all the time. He was really sick. And he was so weak from losing a lot of weight when he first became diabetic. He just went thin. I went to see him a few times to talk with him. He was so cold. He couldn't seem to feel the heat. He'd ask, 'Can you help me down the stairs, Violet?' I'd say, 'Yes, I'll take you downstairs.' So we walked down them together. I was dragging a quilt along, too, because I knew he was so cold. As he was lying on the sofa with that quilt, I got another blanket and placed it on top of him. I just told him, 'If you're not drinking diet pop you'll sure be sore from that. You have to learn to drink the diet ones or just drink water.' He kind of became mad because I talked like that to him, but I think he realizes what I was saying - that he was going to suffer from it for awhile, anyway."

"But my other brother didn't listen to me as well," Violet continues. "I thought to myself, 'He's going to learn the hard way.' Some people are easier to talk to than others. And some people are just stubborn. The more I talked to him the more he wouldn't listen!" Violet laughs.

"It doesn't help to be a stubborn diabetic," Violet explains. "I remember how I had to make so many changes to the way I cooked. I had two grandsons staying with me. I said to one of them, 'You're heading toward being a diabetic because you're gaining lots of weight.' When I cooked I'd usually give them what we had. They didn't seem to mind. They just thought it was an ordinary meal. They didn't realize I was putting them on a diabetic diet!" Violet laughs.

"I remember how we used to eat lots of pies. I had to cut us off of them because it was my husband's weakness. He just loves pie," Violet remarks. "I used to bake them all the time. I had to quit it because he just gained too much weight. He didn't know when to stop when there were pies there. So I quit baking them. I said to my boys, 'If you want pies, bake them yourself!"

Free Blood Machines

~

Things You Just Need to Know

"I've been to the diabetic workshops in Vancouver about four times. I really enjoyed myself. There were some things about diabetes that I just didn't know. I wanted to know more!" Violet explains. "I recall one time when my husband came down with me. It was just the right time for him and it was good for me, too. There were people there who had no legs. And there were people who had something wrong with the legs they had. I remember how my husband just soaked up everything. 'That's what I'm going to look like if I don't learn how to take care of myself as a diabetic,' he said to me after. It was sinking in," Violet reveals. "I'd keep saying to him, 'You're going to be the next one. You're going to be like them if you don't watch it. And you won't like it in a wheelchair!'"

"So I was happy he went with me. We learned a lot at those workshops," Violet reveals. "One time there was a hospital worker there who was diabetic. I think he was an electrician. He came in and sat with us. He was just shaking all over. He said, 'My blood sugar is burned out!' One of the ladies quickly got up and got an orange juice for him to drink. It was good for my husband to see this."

"I sure feel the diabetes when I'm really busy. It makes my blood sugar go down," Violet continues. "And sometimes if I'm not too busy it'll go up. I have to keep testing myself with my glucometer machine. They gave us each a free one last year at the workshop. And you know, like my husband, I was really amazed. It was good for both of us to have our own. It made him really happy because it's such a small thing to carry around. We can carry it wherever we go. I usually test my blood sugar once a day, but sometimes there are days when I don't take it. My blood sugars tend to be quite stable now, but for a while there they were going up real high. I had to work real hard at getting them down. Getting them to come down during the winter is another story."

"I have asthma and during the fall and winter I have a hard time with my breathing," Violet explains. "It's cold and I can't walk as much. Instead, sometimes I go on the exercise bike or treadmill machine that we have in our house. My sister-in-law gave them to us. So once in a while I'll get on one of them. I find that by using it I can bring down my blood sugar. During the winter my husband and I get around in the truck a lot when we have to go somewhere. That's what I tell my husband. I just say to him, 'Try getting on the bike.' Before when he couldn't control his sugar I used to say to him, 'You've got to be active and burn it up!' And he didn't seem to want to listen. But finally he found himself feeling his sugar when it was high. I said to him, 'When you feel like that you're going to have to deal with it. Instead of drinking juice or pop, drink water.' And so he's learning to do that. And he's learning to test his blood sugar two or three times a day. I think he's finding out that he's able to deal with it. Nobody else is going to do it for him. He has to deal with it himself. I told him, 'I know that when my sugar is up I have to use the exercise bike.' After a while he started to learn how to deal with his blood sugars. He's doing the same as me now. He gets on the bike!" We make eye contact and smile.

"I find that when everybody is out of the house, I go on the treadmill or bike. It is easier for me that way," Violet continues. "Then I will stay on it for quite awhile. And my husband is doing it a lot more now, too. It makes me think, we've been married 42 years and we're still helping each other out! I remember when I was first married and worked in the old hospital here," Violet reminisces. "I was a nurse's aide and used to think about diabetes. I thought that it must have something to do with what we ate. Later I realized that we are just not that active, living here. A lot of people are still getting diabetes."

"It makes me think about my family and what they need to know about diabetes," Violet reveals. "I have the one daughter and I adopted a son, but I lost three. My daughter is in her forties now. When I was pregnant with the others I remember having terrible nosebleeds. Shortly after that I was asked to adopt a son from our family. His mother had died so I took him for my own. When I lost my own three I was always seven months pregnant. They were always stillborn after my nosebleeds." Violet pauses as she feels the emotional turmoil of pregnancies from the past. "But my son has two boys and I'm looking after my daughter's two older children now. Her other three children are with her in Bella Bella. Her youngest girl is graduating from high school this year," Violet announces. "We are so proud of her and plan to see her graduate there. It takes seven hours to get to Bella Bella with my husband's boat and about twelve hours by ferry boat. The ferry stops here and there, and in Ocean Falls, so it takes much longer. I remember what the boys would say while in our boat, 'It takes seven long boring hours'. They were young then and would get uneasy just sitting, waiting to get there. But I enjoyed the ride!" Violet exclaims. "I have always enjoyed that boat ride, for whatever reason we had to set off."

Diabetic Candies

~

What We Eat and How We Live

"It's good to talk about the diabetes," Violet remarks. "I never really talk about it. No one likes this diabetes. It makes me think of all the changes for our people, to our whole way of living, what we eat, and how we live now. I used to drink pop, but I don't think I had too much pop when I was younger. We just couldn't afford it. And then I worked, so I never really thought of drinking it. It's that way even today. I don't drink much pop, except maybe once in a while when somebody gives it to us as a treat. My husband drinks a lot of the diabetic pop now. It doesn't taste too bad. But I was the worst complainer when I first tasted that diet pop," Violet continues. We both burst into laughter. "I drink it once in a while, but not a whole lot of it. And I don't drink it the way I see some people who just have one right after the other."

"I just can't eat anything I want to with the diabetes, either," Violet continues. "If I eat certain things it will boost my blood sugar way up, especially when I'm not taking my walks. I haven't been walking lately because my leg is really stiff. In that way I think to myself, 'I'll have to control what I'm eating and not eat a whole lot. Sometimes I eat cookies or a little bit of candy, but I don't go overboard. If I do eat too much of something sweet I know that I'm going to have a hard time bringing it down."

"There are candies that are just made for diabetics now," Violet remarks. "One day I had a package in my pocket and moved it to the dresser. The boys came in and took a handful. They thought they tasted really good. They kept saying that they liked them. They couldn't tell the difference. So I didn't say anything to them. When my husband took one and tasted it I told him, 'You know those are diabetic candies.' He looked at me. He really liked them!" We laugh together, picturing his surprise in our minds.

"I remember how I had to stick to fiber in my baking and cooking," Violet explains. "I find that it really seems to help me, especially for a while there when it seemed like I had no energy at all. It was a time when I just had to force myself to move. It was like what the doctor had mentioned to us. I was telling him that it always felt like I had no energy at all. He says, 'Maybe you need to put some fiber in your diet. It might make a difference to you. You have to try it first to find out.' I thought about it. My husband and I expected the doctor to give us some kind of pill to take. But I said to myself, "It's up to me now to do this. So that's what I did. I figured that I am the cook and nobody knows what it is I'm cooking." We laugh.

"One of the boys was always saying to me that I was having a hard time," Violet continues. "He saw that I didn't have enough energy. It made me realize that I had to do something about it. I sure didn't feel like getting up in the morning. It took a lot of effort.

And it took a while to realize that I was having too hard a time with my house cleaning. It is still a chore, but not like it was before. In changing what we ate, I changed how we lived."

"I started baking with whole wheat, but I really didn't know what to do with it," Violet reveals. "I never did get an education. And so I had to look into it, really look at the books to find out what I needed to do. I still keep a sheet of paper on what food has fiber in it on my refrigerator. If I use fresh blackberries or raspberries, I know that they're a good source of fiber. I remember how I had to look at that paper and all the other diabetic papers. I had to really run my mind through them when I started to make changes. Once I learned to do that I began to make it a habit. Now I like to use bran or oatmeal. And then I'll just switch them around. My husband will look at me and say, 'What's this now?' I tell him that the bran is a different color than the oatmeal. It's darker. You see my husband used to like to have just toast and coffee in the morning, but then his blood sugar would go sky high. So I said to myself, 'I better start cooking some porridge!' That is what I did. I cooked different kinds and it started to come down. And instead of two pieces of toast, he has one. So we both have our porridge with bran sprinkled on it in the morning and we're both quite satisfied."

Popsicle Treats

~

Working in the Hospital

"I had a little girl when I was quite young," Violet explains, her eyes soft with moisture. "It seemed to just stop everything when it happened. That's when going to school ended. And I had to go and get a job to try and make ends meet. I was young so my mother and father looked after her. She has always called them Mom and Dad, and me her sister. It was when they were both gone that she started calling me Mom. She always knew that I was her mother, but she loved my mom more because she was really good with her." Violet pauses, recollecting the tenderness revealed in such thoughts. "So I got a job and worked in the old hospital here. It was in the fifties when I started. I began working in the laundry and then moved to the kitchen. I really enjoyed helping in the kitchen because I liked the lady who was working there. She was so nice to me. After she retired I became a nurse's aide. I did that before I got married."

"In the fifties there weren't many people living here and hardly any cars. I remember when I was nine years old. Mom had taken us two kids down to the hospital in a child's buggy so that I could get my tonsils out. The buggy was the kind that was really deep and the two of us were able to sit in there. She pushed us back home again in it. My throat was really sore. I was given popsicles to ease the pain."

"I didn't go back to work after I was married," Violet continues. "I already had my little girl, so I stayed home and looked after her. But I enjoyed my work there. I really enjoyed the people. We got along so well. I remember a woman who was so much fun to work with. She was always laughing and making everybody else laugh. I think about them, sometimes, and how happy we were there working together. Another woman later died of diabetes. She had a convulsion. I was really shocked. They rushed her to the hospital, but she didn't make it. It was too late. She wasn't even that old. I felt really sad, because she was a really jolly, happy person. I liked her. She went into a coma so quickly. I had talked to her a few days earlier. Then I got the news about what had happened."

"Her passing made me think about those days when I was working. There were people who were prejudiced then. I worked with a few of them. They wouldn't let me touch their bed. The matron went right up to them and just got mad! She'd say, 'You can just leave your bed like that. Nobody is going to touch it. It's Violet's job to make your bed'. I would run into a few people like that in the hospital. Some of them weren't patients. I used to do some crying. The matron would come over to me and say, 'Don't feel bad. There are people like that in this world.' There were people like that in the valley, too. We knew them for years. I was young then and I didn't know why they were like that, yet they would talk to you. But when it came time to change their bedding and fix it up, they wouldn't let me touch them."

"There are still some people like that around here. My boys can't take it when they see it. They get real angry inside. I say to them, 'Don't let it get to you. I had that happen to me in the hospital a few times and I used to break down and cry.' One of the boys got into a fight with a fellow who came right up to him and punched him in the face. 'What was that for?' my son said to him. 'I just don't like the looks of you guys', he said. But I told my son, 'Don't let it get to you. It doesn't have to affect the way we are living now.

It doesn't always go that way. You don't have to look at all white people like that because of one person. We have some good friends up the valley and we like them. We give them fish and they give us vegetables.' But for our son it has been hard."

"I remember our parents telling us that. My father was from Bella Coola and my mother was from Bella Bella," Violet explains. "Mom said she worked in a mine and my father was a fisherman. She would tell me how lonely she was when she was young. She never had a mother or father, but had a brother. She had been in residential school for two years. She went down from Bella Bella to Nanaimo and then to Alert Bay. There were lots of boats going back and forth, but she'd tell me how she had always been alone. She had family, but no one could really afford to pay her way back. Then she met Dad. She didn't have children right away. When she did have them she had seven of us. I was the only girl! I said to her, 'Mom, why do you want to have so many kids?' At that time I was always babysitting. She began telling me about herself when she was young. Mom would say, 'I was alone a lot and you are my joy!' She used to say that to us. She used to say we had a happy home. Mom would have had more children, but she lost several. That is why I think she had so many of us."

"Mom never really stayed in Bella Bella," Violet continues. "She was either in school in Alert Bay or living in Nanaimo. I asked her one time, 'How did you meet Dad?' She said, 'Oh, he was a fisherman. He was fishing around and outside Nanaimo. He was in there and out of there.' She decided to get on his boat and come this way. She had made up her mind to do that. And she worked in the hospital here for about twenty years. I was working there when she retired. My brothers all call me Mom now. As I get older they say I look just like her."

As these thoughts make Violet smile, maternal affection emanates from a centre of physical being and wellness. And it causes me to think of my own birthplace, a place called Nanaimo.

Healing Tea

~

Traditional Medicines

"One of our friends got a real bad ulcer on his leg awhile back," Violet reveals. "It happened on a big fishing boat. He went past something and just scratched his leg. Before he knew it the ulcer turned into a sore that was raw and deep. Our other friend went and got some healing branches from the back of his place. He peeled off the bark and boiled it. He gave that gallon jar to him and told him to drink some of it. He also told him to put it on his leg ulcer. That's what our friend did. The ulcer was just about closed up when he ran out of it. So he went back to the fellow and asked for some more. He carried on with it and that ulcer never bothered him again. He was so happy it healed up and that he got rid of the pain."

"We sometimes use those branches for medicine," Violet continues. "If I have it I will take some. Then there is another tea we make from a particular type of bark with needles that is popular with our people. We just drink it. I scrape off the needles and bark until I get to the green or yellow fleshy part of it. Then I boil it up. I usually take it once in a while, but not all the time. I think that some of our medicines are good for diabetics. I just haven't got into it enough. My niece does. She's always finding all kinds of herbs to take and puts them in the bark teas to drink. She finds them between here and Anahim Lake. I might be a totally healthy person if I got into drinking it, too. I just don't think of drinking it all day long. I drink about a cup of it a day."

"A lot of people I know have gone into a wheelchair from the diabetes," Violet reveals. "Some of them can't even see now. I was talking to my husband about it. There was one lady we knew who was walking and then, all of a sudden, she was in a wheelchair the next day. I said to my husband, 'Oh dear! We're going to be like that if we don't watch our diet, believe it or not. ' He looked at me and said nothing. He never thought he'd ever lose his toe, so I think he's watching himself a lot better now."

"I know with diabetes that it sometimes feels so hopeless, as if nothing is going to change in my life," Violet explains. "That's the way I tend to feel, but then I will run into other people who are living with diabetes. I see how they are feeling really bad. They feel sorry for themselves. They think their life is going down hill. I say to them, 'Things can change if you pay attention to your whole life, especially with what you eat. But you have to read your diabetic information. It tells you what to have at each meal, what to have in the mornings, and what to have before you go to bed. It'll work! You'll feel better if you follow it.' They look at me and at each other. I don't say anything. They forget all about reading the papers they have. They have to go home and dig them out. They don't remember where they put them. I say to them, 'You have to follow it every day so that you can figure out what to eat. You have to follow it!' I tell them that I limit myself with some things I eat, like potatoes. And this man says to me, 'I take a whole plate of potatoes.' So I say to him, 'No, that's no good. You have to learn how to adjust your own stomach now.' And then he replies, 'Oh, that's why we're so miserable!' That sure made us laugh."

"So I told them that if they want to eat a lot of potatoes, they should try taking a lot less and eat more of something else," Violet continues. "If there are vegetables to choose from, take more vegetables. If there is salad, take more of it. One woman says to me, 'That's what we're doing wrong. We eat too many potatoes instead of having salads and vegetables.' I reply, 'And have fruit instead of finding a cookie. Or if you have the right kind of cookie, you might want to save it and eat it during your coffee break. There are cookies you can buy these days that are made especially for diabetics. You'll notice it tastes different at first, but you'll get used to it. Anything is hard to change at first, but it stops being a struggle later on.' 'Ok,' she says to her husband. 'Where did we put those papers? I hope we didn't throw them away.' Two days later she told me how they'd cut down on the amount of potatoes they were eating. She used to cook lots of potatoes every day."

"This same woman says to me, 'It was a real change right then and there when you talked to us. I felt so miserable. I just felt like I wanted to die, but it has made such a difference. I'm serving up more cooked vegetables, too!' So I told her to eat more unsweetened fruit. She said her family doesn't eat much fruit. I told her to eat bananas and that they have potassium in them. I said to her, 'You eat some of that banana. Your body probably needs potassium. That's what you're lacking!' And she was listening, because the next time I saw her she was on her way to go shopping for more fruit and vegetables. She kept thanking me for it, too. She said that before our talk she just felt like she wanted to lie down and sleep, and never wake up. She said to me, 'We were heading for our graves.' I told her, 'When there is a diabetic workshop, go to it! That's where you learn. Go to it!'"

"Others have told me, 'Oh I don't like this diabetes!' I've been sipping something to drink and they'll tell me what they're drinking. Just the other night we were sitting with a fellow who liked his beer and his wife her pop. He says to me, 'I know I like this too much.' His wife was nodding her head beside him. 'Now I have to quit it. As soon as I drink one I start to feel sick. Is the diabetes doing that?' 'Yes,' I reply. 'You're drinking something that makes the blood sugar in your veins shoot right up!'"

Mom's Sickness

~

Keeping Active

"Many of our people here are diabetic," Violet recalls. "It seemed like in the 1950's nobody had it. We hardly heard of diabetes. Now we are loaded with diabetics. Probably more than half the aboriginal people living here have it. Another one of my friends has just learned she has it. 'I must be going blind,' she says to me. She didn't even know she was diabetic. It was her daughter who took her to the hospital. They told her that her sugar was so high that she'd need to be admitted to have it adjusted with insulin. And that night I was telling this to my brother, because he is overweight. I said to him, 'If you keep active and keep walking you might not get diabetes. But if you are going to go home and lie down on the sofa, you're going to be diabetic.' I don't think he eats a lot of junk food, but I know he eats too much at the table."

"This morning I was thinking of when my mother was diabetic," Violet explains. "I never knew what being diabetic was like. I asked question after question, but never really knew what it was all about. I knew my mother was not well, but I just couldn't figure it out until I got it. 'You'll find out if you ever get it,' she would say to me. 'Oh, I just hope I don't get it,' I'd reply. I could see her suffering. Her blood sugars were always high. And she was kind of stubborn, too. She didn't want to drink water. She would rather drink juice or pop. At that time I didn't know how to go about living with diabetes."

"Mom couldn't explain what diabetes was very well, because diabetes was something new to everybody," Violet continues. "She'd say, 'I just have a pain.' And I would think to myself, 'There must be something more to this sickness.' We ended up going to a diabetic workshop together once. She didn't want to go again. I said to her, 'We should go again. I think it will help you'. She got angry with me, but I knew she was angry at the diabetes. I said to her, 'I think it would help you if we went to the diabetic workshop again'. But she wouldn't go. She had only been at the first one for three days. I kept saying to her, 'I think it would be good to go to the workshop and learn more about diabetes'. Then not too long after that, she was on insulin. She just couldn't keep her blood sugar down. Although she tried not to be, she was really angry. She tried to deal with it, but I think the more she thought about it the more pain she was in, and the angrier she got."

"I remember how Mom had kept some information about diabetes in the house," Violet reveals. "She gave the whole family the papers to look at. So I quickly wrote all the information down and began to tell my husband what was in them. I said, 'Do you know what diabetes is about? It's where the pancreas is. That's where the problem occurs.' At the time my husband was overweight. He just didn't know how to limit himself when I started cooking for him. 'I'll never get that!' he'd say to me. That was his attitude at the time. I said to him, 'Don't be too sure. The way we eat, I'm going to cut down on my cooking, anyway.'"

"My husband was overweight and having a hard time," Violet remarks. "I don't exactly remember when he began to feel sick inside, but he started to drink lots of water, juice, and pop. He couldn't satisfy his thirst. He'd say to me, 'I'm sure drinking lots of water, and the minute I'm finished I go straight into the bathroom.' So I told him, 'I think there is more to it. I think you may have diabetes.' And I remember how he would lie down on the sofa and say how drained he felt. I said to him, 'I think I should make an appointment for you with the doctor.' Then he started losing weight really quickly and his clothes were getting big. And he just wasn't saying much. Then one day he says to me, 'I think I spoke out too quickly about this diabetes.' We laughed. He knew he had it!"

"I made an appointment for him the next day and told the nurse what was happening," Violet explains. "She says to me, 'You better send him down right now'. So we went to the hospital and they took him in right away. They weighed him and got him started on insulin. He was in there for almost a week before they let him come home. But I was glad they were able to figure out what was happening to him. Later, after he returned home I told him, 'I can't tell you everything I know. You have to learn it yourself at the diabetic workshops. You have to listen to them there. You will have a chance to see how the needles are given and to practice on yourself.' I think that was when he kicked himself for not going to the workshops when I was going. He mentioned that to me later. He said, 'A person can still learn more, even though he has been a diabetic for years and years.'"

"I remember how I was heavier than I am now," Violet continues. "I cut down on my eating over the years, because carrying my weight around with my weak ankle wasn't the greatest thing. And my knee wasn't good either. I used to take too much food. If I had some roasted meat, I'd take a big scoop of potatoes with it and force myself to eat it. I just took too much of everything! So I cut down a little at a time and got used to it. I can't eat much now. When someone serves me a whole plate full of food, I have to say to the server, 'Oh, that's too much! All I want is one piece of meat and one scoop of salad with some fresh vegetables.' I wanted to have more vegetables than salad, because it was potato salad and coleslaw. There was too much mayonnaise in them. So I took quite a few of the carrots and just a little egg salad and coleslaw. I said to the server again, 'A lot of the older people don't eat a lot now. They say it's too much, what is on their plate.' She just looked at me. I understand, now, what they're going through."

Salmon Oil

~

Living on Fish

"We have lived on salmon all our life," Violet explains. "We place it on a big bonfire and stand it up for the fire to cook. Spring salmon is really rich with fish oils. I also like to cut and smoke it overnight. The next day I'll put those pieces on sticks to dry. We call them barbecue sticks. There is a way to put the sticks across the fish so that they don't fall off. Then we set them down in a prepared hole by the fire to dry more. It reminds me of how I had to soak my fish in saltwater one time. It was hot and the flies were bad. I had stopped putting salt in my fish, because I was afraid of my husband's high blood pressure. So I was a little worried, but it didn't bother him."

"My husband used to love his salt and eat bags of potato chips," Violet continues. "I wasn't much for potato chips or pop. It was the candy that I used to crave, especially lifesavers. I remember one of our friends giving me a Classic Coke soft drink. 'You want some?' he asks. So I took a sip. I said to my husband, 'Taste it. It's really sweet.' We were used to the diet pop now. My sister-in-law and her husband even found it sweet. They were drinking Classic Coke and a few hours later felt really dry and thirsty. Her husband was on his way to see the doctor, so she went in with him. They took her blood and tested it for sugar. It was really high! The soft drink was still in her, and they told her not to drink it. The doctor said, 'You either quit drinking pop or you go on the diet ones.' She has been on the diet ones ever since."

"I have a sister-in-law who always wants me to walk with her," Violet indicates. "She comes and picks me up and we head down the road. She parks the car and we walk near the water. I'm used to walking, but my one grandson always wants to drive me to the store or wherever I need to go. I'll tell him, 'No, I have two good legs, yet,' But I used to be 199 pounds. I never did go over 200. Right now I'm 160. I'm watching myself, especially when I go for coffee. I usually try to have a banana and a few no-sugar cookies. I found out that when I put those cookies on the table for my family, they all but disappeared. I was surprised at how much they liked them."

"I find the best exercise is during the fishing season when I'm cutting fish. I just walk back and forth all day," Violet reveals. "I have to bring down the hose for the salmon and use the wheelbarrow. I spend the whole day working at it. I'm not as fast as I used to be and the ground in our backyard is not very even, but as long as I watch where I place my feet and where I walk I'm alright. The best part is the next day when I go back into the yard and put all that fish on sticks. Then my husband builds a fire and we cook. When each batch is ready I start thinking about the look on my brothers' faces. I love that look they give me as I pass them the salmon and they realize it is still warm."

~

Early Motherhood

"The daughter I had when I was young is married now," Violet explains. "I had trouble then when I had her, and was really bitter for a long time. I really hurt. But I'm very happy for her now. She has three boys. She doesn't live very far from us and comes over almost every day. She is quite happy and getting close to the rest of the family. So my two daughters get along well together."

"My husband and I enjoy all our grandchildren when they come around," Violet continues. "We've been married over forty years and he fished for most of his life. I remember when he got a new boat one year. He really wanted a new boat. His old one was always dripping from the roof and leaking from the bottom. He had done really well one year so I said to him, 'Go ahead. Go for it and get a new boat!' He wanted to buy me a car, because the one I had was breaking down now and then. I said to him, 'No, it's better to hold off if you want a boat.' So he flew down to Vancouver Island with a friend to get the kind of boat he wanted. He ordered it and they worked on it through the winter. By early spring it was ready. He always liked that big boat."

"I remember going with my father in his small boat," Violet recalls. "Dad always used to take the six of us. Mom didn't want to leave any of us behind when they went fishing. The boat was small, but we didn't care where we slept, as long as we were there with them. Dad would fix or move things around. He put a board on top of the engine. He worked on it so that it would be sturdy enough for us to sleep on. It worked out fine with all the kids on it. We didn't complain. We used to just love it out there."

"We used to go to a certain place," Violet continues. "It was the middle of July and it used to take 12 hours to get there by boat. It would just 'putt-putt-putt' all the way to where we would fish. We were just all together. My mother didn't want to leave any of us behind, because we were all quite young. And my father never wanted to leave Mom behind. She would say to us, 'If I go away, you're going to come with me, all of you!'"

Later, as I thought about these moments, I became aware of how quickly Violet and I had traveled together through body and mind to places of meaning hidden in separate lives.

A Two Year Stay

~

The TB Hospital

"I went into a tuberculosis hospital in 1956," Violet reveals. "I got it from working in the Nanaimo Hospital. The laundry there was cold. I remember a cellar that was super cold. The floor was cement and I just couldn't get over my chest cold. They didn't want me working in the laundry, but I really liked it. In those days they had clothes lines going across the room, zigzagging. We hung the clothes there, but I liked to hang them outside in the cold winter. The matron would help me, because together we were strong enough. But it was standing on that cement floor while I was washing clothes where I really got cold. That led to tuberculosis. I just couldn't shake that chest cold off."

"I was isolated in that hospital for two years," Violet explains. "I remember feeling so weak. I would stay in bed, but some of the other girls wouldn't do that. They'd be jumping and dancing around. They were the ones who never got better and just stayed in hospital. I was determined to get better. All I did was sleep, eat, and sleep for a long time. About three months later I had an x-ray. I was healed."

"It was a lonely time for me," Violet continues. "I missed my family. I had left in May and come home in May, but it was two years later. My mother just cried when she saw me. And I was so happy to get better that I never smoked again. I tried it when I got out but I got sick. I just told my girlfriend, 'I don't think it's meant for me now.' I didn't even miss it. But before I was sick, I'd have that craving every time I smelled cigarette smoke."

"I know smoking is bad for us," Violet remarks. "One of my grandsons says he smokes once in awhile. He says that if somebody asks him, 'You want a smoke?' he'll take it, but he doesn't really want it for himself. My other grandson sees it differently. He tells me, 'I need a smoke and I'm going to die if I don't have one.' And I say to him, 'You're going to die anyway with them!' He just laughs when I say that to him."

"Just the other day I was talking to a couple I know about how we take care of ourselves," Violet explains. "They're both diabetic. She says to me, 'I was hoping I would never get this.' I reply, 'It's the way you're living your life.' She had made a joke about how she doesn't take care of herself. She was drinking every weekend and feeling like she was drinking too much. It was causing her to feel sick all the time. I say to her, 'Are you waiting until your diabetes stops you?' She replies, 'I just don't feel healthy anymore.' I told her, 'I don't think I'd last long if I were you. I'm having a hard enough time right now, even though I'm in pretty good health. But it's entirely up to you. You know the right and wrong you're doing. She says to me, 'Yes, I know. I guess I'll have to try and taper off it, now that I'm diabetic'. I reply, 'If you keep on the way you're going, you're not going to last very long, because your blood sugars will be high all the time.' I had to tell her that, because she was in really bad shape and had diabetes on top of it."

"I have talked that way to others who have diabetes and continue drinking," Violet continues. "I used to talk to one fellow when he was hung over. He was drinking water, pop, and juice, pouring it in and sweating it out. I say to him, 'Your body must take a lot of punishment from that stuff. You pass out. You wake up. And you start drinking again. You don't eat or sleep right.' I explained to him how he was abusing his body. He seemed to know he wasn't in the best of health. But I saw him just recently and was talking to him again. He looked like he had been off the drinking. He was out cutting the grass. He stopped the lawnmower to talk. I usually didn't like to go see him, because he was drunk all the time. But I really enjoyed talking with him that day. It makes me think about that other couple I had talked to. They ended up dying of diabetes. They both went into a coma and never woke up. They knew when their blood sugars were high, but didn't seem to care."

As I listened to Violet's stories, I was struck with the poignancy of how the body in one instance had lost the soul as a guiding beacon, and in the other had discovered it in the modality of physical wellbeing. It caused me to contemplate how even though healing bodily change may become an urgent necessity, we differ in our resourcefulness to relinquish such perceptions as risk and fear that feed the devastating characteristics of an addictive life. Without a viable connection to the soul, we suspend through soulless perception, judgment, and thinking our options, our choices, and our ability to accept what is real and tragic. And it gave me reason to pause and reflect on the writing of Le Guin (1989):

> Only the imagination can get us out of the bind of the eternal present, inventing or hypothesizing or pretending or discovering a way that reason can then follow into the infinity of options, a clue through a labyrinth of choice. (p. 45)

Amazingly, when we soulfully, honestly, and humbly accept the way we are viewing and perpetuating our own destructive situation, acts of healing have a better chance of springing up from the centre of our humanness, rather than from the addictive symptoms that are in response to overwhelming emotional pain, misery, and grief. Thus, we choose to be swallowed up by our willingness for demise to happen, or we choose to be made naked and vulnerable by our desire for something new to take hold. And it is this willingness to be nourished by the healing force of life during circumstances of dire emotional and bodily need that we imagine a new way of being, which differentiates us from each other not only through exhibited spiritual resiliency, but also through capacity to know in an integrated way the synergistic workings of our mind, body, and soul.

Ripe Huckleberries

~

We Were Good Kids

"When my husband and I were not fishing we were picking berries," Violet reveals. "One time we managed to collect five pails of ripe huckleberries. We just kept picking until there was none left. It reminded me of when we used to race home and help Mom with them. She was busy all day with those berries, cleaning them. When my Granny was sick, she told my Dad in her own language that she wanted to taste those huckleberries again. She says, 'I want something really sour.' My mother would freeze them in plastic containers and dry some as well. She gave my Dad a couple of bags to take over to her. Granny had something wrong with the inside of her stomach. It was a week later that she died from cancer. She loved huckleberries. She didn't taste the sourness. My Dad would just scrunch his face, watching her eat them. They were real big huckleberries, too. He'd tell her how many we'd picked. We used to go berry picking with her and she was always telling us what good kids we were. And she would tell my father that we are still good kids. " Violet beamed with the memory of such praise.

"Wild huckleberries were such a natural thing to eat in those days," Violet explains. "I've really gone back to eating more natural foods. When I first got diabetes I found it really hard to snack properly, because I used to just grab anything to eat. I managed to control my blood sugars, but they were up and down for a while. It was really frustrating! Back then I didn't like to eat much dinner, but now if I did that I would start to feel myself shaking. My body tells me that I need something in me to control that from happening, but it took me a long time to figure it out."

"I was angry for awhile," Violet continues. "I remember talking to somebody about it. She was diabetic, too. I said to her, 'Oh, it is a real nuisance being diabetic, because I have to take my pills at certain times. I don't like being loaded with pills. I think I'm more loaded with pills than with food.' She replied, 'Yes, I feel that way, too.' I had made her laugh. I didn't want to go on insulin so I worked on my diabetes. I worked on it so my blood sugars stayed down. Some people don't want to work on their diabetes. I see that. Some of them just don't care if they don't take their pills or watch what they eat. But I ended up telling this woman, 'I need to be working with my food and pills together. The diabetic medicine flows in with my blood. It makes my body strong as long as I eat right.'"

"These conversations make me want to try to get to those people who don't have diabetes, yet, to talk about it," Violet reveals. "When our friends come over, I buy raw vegetables and have it with dips. They all go for it. And sometimes we have meat, cheese, and crackers. Some say, 'Don't bake any cakes.' I reply, 'I've forgotten how.'"

"One time a few of our friends came walking into the house with a cake," Violet remarks. "I said to my husband, 'We better try and not have much.' So I had just a small piece and my husband had the same. I was really surprised, because he used to take such big pieces of cake and now he doesn't do that anymore. I think we both see that some of our friends with diabetes are gone now. I remember being at a service in the church. They had some goodies on the table and my friend just took one of every kind. Not long after she went downhill with her diabetes. She lost her eyesight. I tried telling her, 'You should try and not take so many sweet things.' She said to me, 'No, I'm taking them home for my family.' But that's not what she was doing. She was taking them home to eat because she really liked the goodies."

"I know it's hard to change. My husband was a diabetic before me and I remember what I'd say to him when I first had it, 'There's nothing good in talking about diabetes, because I don't like it!' He'd say, 'You have to live with it now.' And it makes us laugh, because we're still talking about having to live with it. Diabetes is like that. It has made us think about what we've been through."

Young Years

~

Living in the Valley

"When I was young, the house we stayed in was cold," Violet explains. "We didn't have any insulation in it, but we didn't mind. We had one heater that was in the front room and all the kids moved in there. It was the warmest place in the house. It was in the fifties, because I was born in 1938. In those days it was cold, with lots of snow. The east wind usually stayed for a month. It was hard to keep the house warm. Everything was frozen in the kitchen. Mom would bring all the pots and pans, as well as the water, into the front room and place them on top of our stove. Then we would block off the kitchen so that we could keep the rest of the house warm. Through the years, Dad tore apart the plywood walls and began to insulate. I used to help him buy the new plywood."

"You know, we were all healthy," Violet continues. "Even though it was cold, nobody had a bad chest cold. We used to pack our water to the house from the creek, because the first thing that froze was the water. We never complained. Nowadays it's not cold by comparison. I remember how we used to go up the mountain behind us after our chores were done. We'd play in the snow and slide down the hills for hours. My mother would say, 'If I don't get my bread done we'll never eat.' So I would help her make bread and put the loaves in pans to cook. She never seemed to mind cooking our meals. She was a good mother. And my father would bring home deer meat and mountain goat. That's what we used to live on."

"I remember how Dad would cut up the deer and moose meat, and cook it in the smokehouse," Violet remarks. "I just loved the broth we made from it. It tasted so good. And we would drink lots of it. Mom said it kept us healthy. I remember my brother saying once that he didn't like wild meat. Mom told him, 'You eat it, because we don't have anything else.' Mom knew how to cook it so that it didn't taste too wild. My brother finally ate his dinner and grew to like wild meat. I would help Mom and tell him he couldn't be fussy about it. I would say, 'If you become a rich person or find a rich woman, then you don't have to eat it.' My mother just grinned at us when she heard me."

"Sylvia, these stories make me think of the days that have come and gone," Violet reveals. "There is a teacher I had in those days that is coming to Bella Coola this weekend to visit. There used to be a small building behind the hall that was our school. She was one of the teachers I had about fifty-one years ago. I want to see her. And I've been talking to different people who were her students, too. 'She must be in her eighties now. It's amazing she's coming to visit us,' I tell them. It's going to be quite something to see her."

I agree with Violet. And with such precious thoughts appearing as goose bumps on our tightened skin, Violet and I carefully walk down a steep flight of stairs to the front of the house. She steps a meter into the yard and stands beneath the enveloping branches of a forgotten tree. She smiles with the fresh lightness that becomes her. It is easy to press the shutter of my Nikon closed, freezing her stilled image in the commotion of our fixed memories.

In what follows, I examine feeding the diabetic body, exercise and body weight, body discomfort, on being itchy, working on diabetes, and figuring the diabetes out through Violet's narratives. They are stories that shed new light upon the lived body in ways that call forth the aboriginal experience of diabetes as a gateway to aboriginal healing.

Feeding the Diabetic Body

Whether influenced by historical, social, or personal convention, Violet's reflections of feeding the diabetic body not only included perceptions of healing an ill life, but also included perceptions of healing the body in a process to make it whole. By venturing to differentiate aspects of the lived body from an illness narrative, we were able to temporarily study the lived body from a diabetes experience that reflected it positively, as well as from those that were grief ridden and worrisome. In order to understand diabetes as a gateway to aboriginal healing, it was imperative for me to recognize the deep significance in the process of healing and reclamation of wholeness that was inherent in the diabetic knowledge Violet possessed. For in the physical appreciation of the body and conversational embrace of its meaning, we came to know experiences of diabetes in profoundly optimistic ways. And in the optimism of lived diabetic body encounters is Violet's telling of a new story that allows us to perceive an immediate primordial sense of hope and aliveness within them.

As Violet related to the people in her world, she embodied her motherhood. Her stories revealed looking with motherly eyes at the frustration diabetes incurs in the lives of others, the setbacks diabetics endure while resisting the inevitable, and the despondent attitudes of close relatives as hopes fade. In these perceptions of lived body I considered the inclusion of body - physical diabetic pain and suffering - and how we directly experience them in our lives. And it was also to contemplate the release of these moments as if they were the images of disease evaporating into born again spaces of the future – *diabetes as a gateway to aboriginal healing.*

From a point of view of feeding the diabetic body, Violet and I inquired not only into the healing process that was transpiring in and around her, but also into the small steps she was taking that considered healing as a sacred connection between wholeness and being. During our conversations, we began by talking about the presence of diabetes in her life and in the lives of others, which she viewed as being practically unknown among the Nuxalk People before 1940. It led us to realize, contemplate, and share with awareness and trepidation the rapid progression of diabetes among all peoples, especially the indigenous nations. It was a stark realization that caused Violet to consider how its presence on her mother's side of the family was more visible than on her father's side. For such thoughts led to the pondering of historical influences associated with change that related to a transition from a physically active life to a sedentary one. And in those changes came further considerations of diabetes and a diet high in fat, sugar, and salt, as most food was no longer coming directly from a way of life with the land.

Violet's stories not only reveal her deliberate acts of feeding a diabetic body and its connection to healing, but also of other diabetics whose careless acts have led to a disconnect of bodily complications. As I situated Violet's stories in an experience of research, I realized how her narratives had become known to her as *feeding stories.* And in them I saw how she was prompted to integrate a pattern of eating into her day to day life that was more aligned with a wholeness of being.

I believe Violet risked telling these stories because of how she experienced positive changes in blood glucose control and in the loss of significant weight. It was in such a lived bodily space that she tapped into an innate ability to participate in her own healing. It was a process of healing that involved herself as well as those around her. And it was a state of body and mind that went beyond the immediate and into the nebulous dimension of what may be considered the realm of practical wisdom where humanity, itself, is tested. For in situations of human culture, Violet not only anchored herself in experiential knowledge, but helped others who struggled to find the healing pathways they belonged to.

Such personal developments toward healing reestablish the ability to cooperate and share, whereby an interdependent web of diabetic people, families, and friends communicate their physical needs, desires, values, and life purposes. For those who discover the strength to reconnect themselves in tradition and culture find additional ways to extend, further, diabetic paths of healing. And in that healing arising from the forcible persuasion of being diabetic is the learning of a new discipline. It is a personal discipline characterized by fine adjustments that reveal how the diabetic body wants to be fed. The words of Lafromboise et al. (1990) shed further light on the experience:

> Many American Indians attribute their ... physical problems to human weaknesses and the propensity to avoid the personal discipline necessary for the maintenance of cultural values and human respect. (p. 630)

In generating such thoughts, a window through which Violet viewed a disciplined embodied self opened up a physical interior world that provided a new place upon which to gaze. For in such reflections also came the responsibility to ensure that those around her had an opportunity to witness their own healing potential, which Violet perceived as a shared one. And in it there existed an orientation derived through a diabetic lens that continued to sustain a renewed connection with the life blood of family, friends, and community, as well as culture.

In this context, feeding the diabetic body was viewed as giving food, or something as nourishing as food, with the purpose of feeding not only the body, but the mind and spirit as well. It is the process of eating food, of which supplying and preparing food are integral parts of the experience. And it is the provision of what is needed for a diabetic body in order for it to exist, function, and grow that illuminates significant new meanings. Violet explained how diabetes interferes with the ability of the body to produce or properly use insulin, a hormone essential for the necessary exploits of energy stored in the food that is eaten. And she understood how this could result in a series of imbalances that included an excess of glucose in the tests of blood and urine.

Violet focused on the bodily experiences of a physical world by responding to the *healing stories* existing in a diabetic one. She realized that her body could usually make insulin but not always use it. With an understanding of diabetes through shared stories, she moved back and forth between narratives of symptom acknowledgement and complications of severe complexity. As further connections to an embodied way of being became visible, Violet's appreciation and respect for the physical sensations elicited by diabetes, grew. For in the stories of increased thirst and hunger were extreme tiredness and intense itchiness, as well as blurred vision. They were stories filled with raw emotions and when diffused amid the company of people on different relational landscapes, established powerful social connections. They were connections that provided a means to maneuver through visible *disease stories* and persisting *chronic and long term illness stories.* In those narratives Violet witnessed her people, frightened by kidney failure, heart disease, stroke, and blindness. And they were stories that revealed burdened bodies in much need of healing.

The notion of feeding the diabetic body in narratives of aboriginal healing is a cultural one. It makes me think that even though Violet was experiencing diabetes and I was not, healing acts associated with eating tend to be culture bound. In terms of culture, Violet identified a notion of spirituality that was closely associated with the natural world. It was an underlying concept that permeated her diabetic life. In understanding Violet's perception of feeding the diabetic body, I came to understand some of the cultural meanings inherent in the land and sense of community in which she was living. For in the sharing of wilderness places, the meaning of diabetes surfaced as part of the revelations experienced there. And these were places remembered by Violet and set aside as locations where feeding the diabetic body held elements of disharmony and imbalance to learn by.

Violet referred to diabetes as an experience of coming to know what not to do. It became a reference point, revealing that established eating practices may not always be compatible with what a diabetic body requires. The incorporation of diabetic eating patterns into a process of healing meant that Violet experienced eating practices that resulted in feelings of not being well in order to learn what to eat, as well as what not to eat. By experiencing a diabetic life that was out of balance, she came to know how to regain a balanced one. And when feeling unwell was many times a result of poor food planning, it was through such experiences she discovered the synergistic effect of combining certain foods that resulted in surges of energy.

The changes associated with feeding the diabetic body were slow in coming for Violet and required considerable experimentation and thought. It was through her honesty that she discovered the intricacies of an eating regimen suitable to the needs of her body. And in examining the ways in which she tried to control, manage, and cheat the diabetes were ways that helped her commit to diabetes as if it were disciplined, sacred work. For feeding the diabetic body required that acts acknowledging dietary changes commenced with her. And as part of the universe, she could see through diabetes, a gateway to healing possibilities.

Diabetes as a gateway to aboriginal healing led Violet into an enlightened approach toward feeding the body. She was reawakened to the responsive powers deep within her, as well as to the benefits that exist when healing is experienced. As a result, her view of diabetes broadened and she began to grow and learn in a realm of new diabetes knowledge. She was a person working in accordance with a body, which had its own unruly expressions and commanded worthiness and respect. For there exists in these experiences, gifts by which life is lived through more fully. And it is through the inclusion of body that we may witness our capacity to heal. Such a perspective brought a semblance of physical harmony and balance to Violet's diabetes experience, as well as freedom from it. As Violet worked on making sense of that experience, she dramatically changed the way she lived.

As time passed, along with many diabetic changes that Violet made came further physical, introspective, and creative acts of feeding the body. Within these realms I saw Violet reach out and extend her ways of doing and being. In reaching out to life she made her strength visible – a clarity that could be seen not only in the diabetic feeding story Violet was telling, but also in the stories told of mothering. I perceived in Violet's poignant experiences of motherhood the existence of a quiet and mindful contemplation that had, over the years, been discretely refined. Such was the connection that I contributed to her relationship with mother earth, to the feeding of mother earth, and to the release of pain and suffering by mother earth. It was a sacred awareness that helped Violet to reconnect with and nurture her own embodiment – the feeding of a diabetic body in ways that spoke of its healing.

Profoundly, feeding the diabetic body is about healing the body. Violet was inspired to learn how to feed her body, to attend to the ongoing involvement it required, and to respond to the conditions that resulted when what she was doing did not work. She felt empowered to open her mind to the wisdom of life as experience and to its healing ways. Relentlessly, the experience of feeding a diabetic body was also to be thrown into a disruption of physicality and altered bodily states. Yet, Violet was able to have meaningful experiences of eating, becoming adept at discovering validated eating patterns that promoted her diabetic body to heal. Thus, they are experiences that shape acts of feeding the body, combine it with a healing process, and situate it in meaningful ways of cultural being. And, significantly, they are experiences that have been made insightful through Violet's acts of mothering. Acts that have evolved from a universal wisdom of ancestral motherhood, honored, and passed down through generations.

Exercise and Body Weight

Personal experiences of exercise and the body tend to be hidden from public scrutiny. Although exercise may ensure that one experiences a strong physical being, it involves activities that are difficult and challenging, requiring an overly developed sense of self-discipline. The stories Violet told of exercising were about the establishment of a regular exercise regime and the restoration of a physically balanced self. And they were stories that revealed the loss of significant weight, an accomplishment that filled me with woe and wonder. The perseverance and tenacity that Violet brought to such a commitment was awe-inspiring. For in the telling of these narratives was an aura of calmness and serenity. They were stories that led us to appreciate the tensions that exercise and the body bring forth through memories of feeding it in new ways. And through a distant flame of hope which taunts to deliver what it purports, they were stories that assisted us to contemplate how exercise results in weight loss when, on a consistent basis, the self becomes not only kind to the body but forgiving as well.

Violet spoke within her narratives of a view that diabetes can affect anyone, with certain risk factors predisposing a person more to its development. Although her increasing weight was tied to diabetes in a disconcerting way, the experience of losing weight had associated with it a pleasurable component. She had learned to take responsibility for its enactment and resulting success. There existed in her close attention to physical activity and inactivity a heightened awareness of conflicted and enjoyable body sensations – spaces of embodied reactions. For in realizing that these particular stories continued to have a perplexing effect on Violet's thoughts, I was reminded of my own exercise stories, how I persevered with repetitious and demanding physical workouts. And I came to appreciate in these conversations a deeper, more embodied dimension of the self experienced in whole stories, of which personal discipline is an honorable part.

Violet was not reluctant to talk about how she tried to exercise. She found ways to control her choice of foods and portion sizes, keep with regular exercise routines, and deal with the setbacks that accompany exercise endeavors. And she found how breaking through the personal barriers of habitual routines required as much courage as breaking through the family barriers of a busy life. The stories of exercise and weight loss that Violet recalled were tributes to her personal enactment of tenacity and perseverance. For they reveal her looking inward and outward, and making visible the determination inherent in her personality. And it is a trait characterized by the establishment of specific acts of exercise and weight loss within a physical existence made much more challenging by diabetes.

Essential to our conversations about exercise and body weight was Violet's primordial desire to heal the body of the destructive forces of diabetes. It made me consider more deeply how all knowledge relating to physicality, health, and illness is culturally constructed, negotiated, and renegotiated in a dynamic process through time and place. For exercise and weight loss may also be seen as culturally bound, because approaches and strategies are composed of philosophical assumptions based on the nature of healing. These thoughts assisted me to reflect, retrospectively, on the phenomenological sense of the lived experience of the body-self and its relation to exercise. Violet and I shared an intuitive sense of our embodiment as existing in relation to other bodies. We tended to feel closely tied to the need for others to exercise and lose weight, as well as to engage in the discovery of their own healing acts. Thus, the constituent parts of aboriginal diabetic healing – mind, body, emotion, spirit, and acts – were viewed as existing in relation to one another, with the potential to promote wellbeing in others.

In terms of understanding the diabetic body through exercise and body weight, further, a singular premise guiding Violet's views was her commitment to a fundamental attraction between spirit and physicality, and between reality and imagination. As she naturally perceived the diabetic person and diabetes experience of illness and suffering from an integrated perspective, she did not find herself trapped by a separation of mind and body. Exercise was viewed as an act of healing and Violet could see the world in its wholeness, with the necessity to incorporate more exercise into it. It is a world where conceptions of the well diabetic body are patterned after the healing body. In both there is an emphasis on order, harmony, and balance. For within a context of living with diabetes, the potential for healing is always present, like it is in the natural world. And it is in the strength of different parts of the body interdependent on all other parts that Violet believes nothing can heal without healing, too, that which is whole. Thus, it was listening to Violet's *exercise and body weight stories* within her *healing stories* that I appreciated how her emotions became the catalyst that extended diabetic knowledge into human motivation. Violet's feelings had brought commitment to human action, an understanding of exercise and loss of body weight that was revealed in the force and intensity only her emotions were able to elicit.

Insofar as emotions entail feelings as well as cognitive directions, social morality, and cultural beliefs, Violet's stories provide an important link to a human capacity of breaking patterns of routine. She was able to conceptualize diabetes and distress as conditions that occur to sedentary and overweight people. For on a relational landscape with people whose diabetic stories were being lived out in a context of illness body narratives, it became clearer to her how to envision something different. She fathomed how the understanding of something different could alleviate such distress through deliberate forms of exercising and the inclusion of exercise into one's daily routine. In viewing physical distress and diabetes as being exacerbated by extensive weight gain, Violet was able to work with an unruly body and diabetic condition in ways that were conducive to her wellbeing. Thus, what accompanied her extensive weight gain were emotions of dissent – a bodily space from which fear, anxiety, and anger were expressed. It was a location from which Violet and I considered many imbalances of the body and the need for personal vigilance.

Violet's stories contained in them the notion of an embodied being and of someone living out, reacting, and responding to a body weight in control of a diabetic condition. It was in reflecting on such connections that she saw how she had embraced, equivocated about, or totally avoided taking steps toward losing weight. Her narratives went beyond the recognition of a body that was overweight. They included a foreseen future condition of diabetes as being both a creation and responsibility of the person whose body was in need of healing. It was a revelation that called out to Violet, providing the reasoning and necessity by which she was able to take action.

I would like to think of Violet's stories as providing a key to the development of a new perspective toward exercise and body weight, and of emotional, social, and cultural sources of diabetic healing. Diabetes is not just an isolated event or an unfortunate brush with nature. And it is not enough to realize that exercise, although an essential adjunct to the management and control of diabetes, will increase the cellular sensitivity to insulin, improve tolerance to glucose, and encourage weight loss. It is in the realization that diabetes precipitates a form of dialogue - *the conversation of the body* - through which nature, family, friends, and culture speak simultaneously. Violet came to terms with exercise and body weight as an immediate personal concern, whereby bodily truths and social validations are continuing to be played out. And it is a concern through which episodes of emotional and social conditioning, fatigue, and struggle are slowly being altered. These are revelations of significance.

Bodily Discomfort

In terms of bodily discomfort, Violet's stories resonate with spiritual and ecological orientations of the past, which resurface in ways that complement a present living space. In that living space, I suggest experiences of bodily discomfort are essential to the understanding of diabetes as a gateway to aboriginal healing. For I have come to appreciate through Violet's narratives, present-day spiritual and ecological healing dimensions that exist as visible components of the aboriginal experience of living with diabetes. And by not attending to these dimensions and their details within specific aboriginal diabetic narratives, such shortcomings constitute a grave weakness that may prevent healing and thwart the return of bodily comfort.

Within spiritual and ecological dimensions of healing, there exist aboriginal healing traditions that are simultaneously knowledge claims about wellbeing, and ways of cultural and social organization, which arise outside the mainstream perspectives of western health and social medicine. As such, they are rich sources of information and ideas about healing and the world. Violet's stories are illustrative of a special kind of narrative that has a way of capturing the complexity, specificity, and interconnectedness of bodily discomfort associated with the phenomenon of a diabetic life. Within our conversations was dialogue to be afraid of, for there were people who Violet knew who were terrified of diabetes and unable to face the physical challenges it posed for them – bodily discomforts that frighten people away.

The words of Tafoya (1995) help to explain this phenomenon:

> In the Northwest and the coastal areas where they have the dance masks, one...is called the transformational mask. During the dance, when a string is pulled the outer mask flies open to show an inner mask.... During the ceremony, pulling the string reveals a human face inside that terrible monster. The idea behind these masks is that sometimes when we are ready to pass through the gate, when we are ready to find out what's inside, it is ready and waiting to bring us something of great value, but only if we're not frightened away. (p. 14)

Tafoya goes on to explain:

> Once a person is ready to go inside the [gate] to receive the truth, the divinity, the divine inspiration that is there, then these [masks] are no longer frightening.... To the uninitiated they are seen as horrifying. However, if they are received on a vision quest, it is powerful and enriching. (p. 14)

I suggest this phenomenon operates within the experience of living with diabetes; that is, to the uninitiated, diabetes may be seen as frightening. Unfortunately, those who are not ready to perceive diabetes as a gateway to aboriginal healing are likely to become severely ill and may even succumb to an early death.

The discomfiture associated with diabetes is a significant aspect of healing, and it not only needs to include an understanding of spirituality but also of ecological sources and their effects. Violet, through a holistic lens, raised questions about a natural diet that was not restricted to a particular diabetic regime, but included the eating of wild meats as a way of halting, in part, the disease process of diabetes and its associated bodily discomfort. Violet's growing understanding of the effect of diet on the progression of diabetes is important from an ecological healing perspective, because it resonates with her heritage - an aboriginal traditional life that has been mostly lost.

The nature of diabetic healing that I came to appreciate through Violet's narratives also compelled me to think, further, about diabetes in terms of a holistic perspective. Such a way of viewing constituted a fundamental difference between thinking about diabetes in terms of healing and in terms of categorical symptoms and complications. Although western medicine recognizes that ecological causes are implicated in disease, the pathological viewpoint locates diabetes as a disease within the person experiencing it.

By considering diabetes as a gateway to aboriginal healing, Violet's stories assisted me to situate diabetes more in the external world in a manner in which I could consider how the experiences of diabetes fit and function together. By rethinking the process of healing, I began to see more clearly how viewing diabetes predominantly as a narrative of chronic illness could be disrupted. Instead, the ailing body and its discomforts could be seen as symptomatic of processes in the external world or of the relationship to that external world.

Violet's story points to the essentiality of healing in our lives, whereby the *aboriginal healing story* can be viewed as an important source of knowing. Violet's personal healing narratives are, indeed, healing stories. In addition, her experiences in guiding a number of close family members and friends to contemplate a significant shift in thinking was a reservoir of learning characterized by sharing her own diabetic stories of healing. Violet innately knew that through the reestablishment of healing in aspects of her external world and her place in it, she would naturally feel better. And whether she experienced a temporary brush with a feeling of wellbeing or a prolonged one, she discovered that it could be made to stay longer. For in the acceptance of diabetes as a gateway to aboriginal healing, she did not view healing as a cure. Instead, she viewed it as making sense of the events and imbalances of a human physical world. And from this perspective she would know what to do, for instance, as knowing when to have her diabetic medicine adjusted so that it would not interfere with such bodily sensations as eyesight and energy level.

Violet's successful healing was found in emotional growth, deepened relationships, an increased perception of the external world, and a spiritual awakening. They all facilitated a more graceful cooperation in the natural processes of life – of which diabetes was one. The conversations Violet and I engaged in were about the inclusion of body toward understanding the natural, social, and spiritual dimensions of healing. And I realized that understandings of holism, spirituality, and traditional life characterized a reservoir of valuable insights that were all part of Violet's view of living with diabetes.

I do not mean to negate the value of understanding diabetes as a chronic illness, no more than I mean to dismiss the value of being sick or uncomfortable. The significance of a healing perspective, however, is its focus on thought outside the confined view of diabetes as a progressive disease affecting a sick body. As with holistic thinking, such an understanding requires the recognition that the emphasis on diabetes as a chronic illness narrative is not necessarily beneficial toward altering the aboriginal experience of diabetes in ways that are beneficial. For the importance of understanding and applying information and knowledge regarding the complexity of changing health practices is better realized across a spectrum of possible diabetes experiences. Violet's stories are examples of such discoveries.

On Being Itchy

As a nurse who is oriented in a strong way to the world of physical comfort, I developed a fascination with the experience of itchiness as an aspect of bodily discomfort that surfaced in the telling of Violet's and other participants' stories of diabetes. I was drawn to reflect on being itchy as a result of high doses of glucose circulating freely through the bloodstream over long periods from a personal stance, imagining what it would be like to experience this kind of intense itchiness. From a phenomenological writing perspective, I attempted to capture within the experience of diabetes actions within itchiness events in a way that is intended to engage, involve, and require a response from those who read it. My desire was to invent in the text a certain space, a perspective wherein the pedagogic voice, based on the participants' and my conversations which speaks for the diabetic person, can let itself be heard. And, as we hear it speak, it may be revealing.

I ruined the skin on my legs to the itchiness last week. It was overly irritating and utterly determined not to spare me the restlessness that accompanied it. So it had to keep its sensation in me. I felt it for hours, during which time it crawled on my back, expanding and deepening its inflammatory wrath. It welled up like forceful invasions in a captive body. I scratched relentlessly, endlessly.

The itchiness was in stormy depths now; the hidden crannies it stalked in went without direction. It rose and intensified on the surface of my ravaged skin, and, when it had wallowed in the wake – tossing and contracting its severe irritation in great waves – receded to a less frenzied state. The itchiness continued to spread up and down, so pervasive I was not even spared my body's secluded parts.

Mostly it just used me warily as I tried to scratch it, and cut out its irritation for my own sanity, if it did not make me crazy. My only retaliation was more insulin, and my only desire its relinquished presence at the mercy of my vulnerable body state. For I knew it would return again if the wrong diabetic choice was made. In the evening hour it left me – as though I were a partly eaten apple somebody had thrown to the ground. I dipped my arms slowly and bent my prickly legs rigidly into the lukewarm water of a baking soda bath. Eventually, at the end, some least action seemed to trigger it off, and it reappeared, delivering me further irritations. Finally, it dissipated slowly away somewhere, far inside me, and out of reach from the destructive force of my finger nails.

Working on the Diabetes

During our conversations, Violet and I discussed the notion of natural healing from several perspectives. We discussed the use of plants in healing by aboriginal people, as an aspect of what is referred to as aboriginal traditional medicine. Because traditional medicine uses materials from the natural environment and requires biological diversity, aboriginal healing developed over many centuries in the Bella Coola Valley. It focuses on healing within which herbs, plants, the health of the land, and a variety of healing practices, including various spiritual ceremonies, are a part.

In aboriginal healing traditions, Violet referred to natural healing as the extent to which a practice resembles something that takes place in nature without a lot of human alteration. Wild meat is more natural than store bought meat, because it requires less human interference. Traditionally prepared salmon and freshly preserved berries are more natural than imported canned fish and frozen berries in the store for the same reason. On the basis of this principle, aboriginal people living with diabetes who have been brought up with an understanding of traditional foods and medicinal plants are, therefore, likely to be natural healing proponents. It was not long before Violet, as a person *working on the diabetes*, was advocating a diabetic diet high in fiber and simple carbohydrates, such as fruits and vegetables, and low in animal fats and complex carbohydrates, such as cakes and cookies. The way she physically felt as a result of these conclusions about diet and later exercise and weight loss, only substantiated the validity of such bodily choices.

In addition to these particular healing practices associated with diabetes, Violet reflected on diabetes in terms of its location within western medicine. For instance, Violet recalled receiving medical advice when her blood glucose remained high or when illness resulted from an unresolved infection, which made her in need of prescribed medications and the recipient of medical care. Regardless of such considerations, a diabetic diet that requires the selection of 50 percent carbohydrates, 30 percent fats, and the rest in proteins distributed throughout a 24 hour day is a challenging process for anyone. Such vigilance is further complicated by the taking in of food that has become entangled with complex social and cultural interactions, instead of merely remaining the pleasurable activity it was once recalled to be. Thus, there exists a tension between health professionals and aboriginal people living with diabetes in terms of understanding how to blend healing ideas and practices from both western and traditional medicine.

As I considered Violet's experiences, the notion of aboriginal healing became a central issue to reflect upon in relation to how it is contributing to a long and prosperous life. For Violet, healing was both personal and social, and therefore an emotional issue that touched every aspect of her life in important ways. And similar to most people, Violet's interest in her health became more pronounced in its absence. Her experiences of living with diabetes turned her mind to perceiving healing ways as her ancestors did, who lived in harmony with nature and were able to survive under the most challenging of circumstances. Such a view focused Violet's attention on the physical body, as well as the broader domains of life that encompass such aspects as wellbeing, harmony with nature, and fruitful relationships with others. These were significant viewpoints that assisted Violet as she worked on the diabetes.

An implication that can be drawn from a notion of working on the diabetes is that its definition is relative to the context in which it arises. That is, how the notion is defined depends on Violet, who is doing the defining, why she is defining it, and the setting in which she is living. Violet defines this extensive domain from her own viewpoint and in a way that makes sense and guides her efforts within it. It is an understanding located in the context of aboriginal healing that has to do with the bodily, emotional, and social experiences of life, as well as the support derived through meaningful and supportive relationships. It has been through an experience of living with diabetes that Violet has explored her capacity to improve her wellbeing, as well as the wellbeing of others.

But most evident within Violet's conversations was the element of shared experiences related to diabetes as a gateway to aboriginal healing. It was a realization that spoke of experience as a valid basis for knowledge, whereby stories are a necessary and legitimate means to understanding the world. As Violet was working on the diabetes, she was playing a significant role in encouraging and supporting others to share their own experiences. In the rich development of dialogue and interaction, Violet was figuring the diabetes out.

Figuring the Diabetes Out

Diabetes as a gateway to aboriginal healing is about the process of adopting new ideas, notions, and healing opportunities in relation to wellbeing. In living with diabetes, Violet experienced the development of awareness and interest, and trial and error as integral aspects that establish healing practices as a part of daily life. And it was in thinking about Violet's storied practices based on specific actions of empowerment that I realized how important authentic commitment is to social relationship. Whether it was the authentic commitment to hearing the experiences of her life from a health professional or close friend, it was in the understanding of those experiences in the words that she used to express them that was powerful and beneficial. For figuring out the diabetes came from mutual actions that focused on improving the circumstances that she wanted to alter. The authenticity of this commitment reminded me of the words of Lily Walker, an aboriginal woman living in Australia:

> If you are here to help me," she said, "then you are wasting your time. But if you come because your liberation is bound up in mine, then let us begin. (cited in Valvarde, 1991)

Violet's healing stories felt bound up in mine and at times we took them apart in terms of mitigating the diabetes, as well as protecting and promoting an explication of what we viewed as body, spirit, and emotions. For in those stories I perceived total acts of healing experienced as the embodiment of human consciousness and hope that brushed up against contentment and happiness. In our conversations were thoughts of the holistic and cathartic nature of being at the center of a healing process, regardless of whether western and traditional medicine could work side by side. In considering how easily Violet's stories of healing and diabetes touched on elements of the natural world and of spirituality, they also accommodated confusion and uncertainty as narrative threads. As I listened to the intricacies of Violet's life narratives, it became easier for me to view her diabetic stories as a natural and common mode of thinking at the center of a healing process. And in that healing process, spirituality seemed to serve as a powerful link between her body and the rest of the world.

As I thought, deeply, about Violet's healing stories, I became more attentive to the importance of those narratives being filled with the spirituality of the natural world. For in Violet's aboriginal ancestry, the world is imbued with spirits and people have an intimate relationship with the natural environment through them. This bond is so deep and provocative that I thought about it at length following our conversations. It caused me to revisit images of mother earth as significant connecting threads of relationship. They are threads containing meaning within such relationships that are reflective of the personalization of the natural world, which is appreciated as an immanent spirituality leading into the contemplative interests of the universe. Such powerful, spiritual ideas about humans and the world, and the experiences from which they come, are the creative opportunities from which we renew our life. Thus, figuring out the diabetes for Violet was about the significance of storied knowledge that revealed diabetes as a gateway to aboriginal healing, which turned a *fragile life* into a *revitalized life*.

As entangled themes from which a rich source of vitality and wisdom rose, Violet's life and my life have a lot to do with inquiring into the experiences of living with diabetes. The actions that Violet took to heal in a world of diabetes were accomplished through a curiosity into new feelings, purposes, and aspirations associated with shifting points of view and interest. It is what enables Violet to be open to the merits of traditional healing traditions and to western medicine, both of which provide her with opportunities for wellbeing. Thus, a focus on diabetes as a gateway to aboriginal healing elicited stories of experience that revealed not only Violet's knowledge of the body, but knowledge of a diabetic healing body.

One of the most symbolic conversations that Violet and I had was in relation to several stories she recalled about hikers who ventured to climb the mountains at the edges of the Bella Coola Valley, and who never returned. As the legend is told, they had always been swallowed up by a particular mountain as if the mountain and the human body consisted of interrelated parts, such as the head, chest, and stomach. For it was interesting to contemplate not so much what Violet had said, as much as how she had said it. And in Violet's words I saw the mountain, like a body needing to be fed so it would be kept big and strong. She caused me to wonder about the existence of an embodied world - the personification of spaces in which people reside and the reflections of body that are perceived in detailed symbolic ways. So I considered, further, how diabetes could be understood as a dismantling of the body, similar to a mountain landslide or an earthquake, if sickness was thought to be caused by disruptions between people and the land, or between an internal existence and the external world.

From these thoughts I turned to the movements of the place I was a part of that spring, and to the seasonal rhythms of fish arriving from the ocean to swim upstream, spawn, and die. For at the return of the Bella Coola fishing season everything, without much exception, is abruptly altered as aboriginal families shift into their own new rhythms. Everything from men drift-netting down the river to women prepping boat loads of fish was set in terms of the natural transition from winter to spring. It was with amazement that I stood on the edge of the river to watch an ancient fishing tradition occur and walked about in a smoke house, gazing at strips of drying salmon held together by sticks of cedar. For I observed in Violet's community how living in a natural and social world had a decidedly human shape and feel to it. And for a brief moment I found myself experiencing the world as an embodied soul. It was physically comfortable, and I felt as though the ancestors had watched me through the eyes of many eagles. They were magnificent eagles, and in my mind I continued to see them, flying back and forth across the river.

CHAPTER SEVEN

Aboriginal Reflections of Living with Diabetes: The Interpretation of Relationship

In this chapter, reflections of living with diabetes are revealed through the conversations I explored with Hazel, an aboriginal woman experiencing the world of diabetes. Within the context of the narrative inquiry, the interpretation of relationship not only reveals a dimension in which human beings share significant interpersonal connections with others, but the construct further elucidates how aboriginal reflections of living with diabetes are embedded in the person's own life narratives of experience. In building a trusting relationship with me, the researcher, Hazel simultaneously began to explore reflections of living with diabetes, thus enabling her to empower her own interpretive abilities of the lived experience that considers *diabetic stories* as being intricately linked to one's *life stories.* I begin this analysis with Hazel's narratives of experience *in living* with diabetes entwined with the human condition and personal interests of her life narratives. In addition, I show that by turning to the phenomenon of a lived research experience I continue to learn what constitutes the structure of everyday relationality by taking up and rendering specific the interpretation of relationship. For in the retelling of our relational experiences there surfaces vital reflections awaiting recognition, of which something tenuous is acknowledged between the self, others, and the world. They are the relations, significantly, by which we interpret and discover the strength to overcome our personal challenges in response to human tragedy and adversity. And it is in such a journey, harboring an endless search for the purpose of life, that we transcend the regret, fear, anxiety, and remorse that are particular to an intricately connected life.

Running Bear

Where black bears and grizzlies lumber among conifers of the valley floor, they can be seen crossing the open corridor of road, running from one side to the other. Out of the sunset they arrive, heading south to eat the silver trimmed fish that jump in the river. Young and shiny, I catch sight of a black bear loping beside the road. It looks for the tender shoots that sprout up, prolifically, in the spaces of open sunlight. Two larger yearlings bound across the road in a playful romp, disappearing into the camouflage of a nearby forest. In that moment I connect to something wild, to footprints placed down by heavy movement, and to a world where animals as predator and prey live out their existence. For in the mood of life that embraces such magnificent creatures it causes me to think, deeply, about how the ancestors had to kill the creatures they loved, the animals upon which they depended. And it causes me to consider how as humans of the extent to which we are interdependent upon the social relationships we choose to create, intimately, with others.

As I travel through the orange glow of a late day, a black bear with two cubs bounds out of the bush and quickly disappears from sight and sound of my rolling vehicle. Then two large grizzlies, their humps etched firmly in my mind, run from one side of the continuous tree line to the other. It causes me to press, firmly, in my thoughts the transient visions of a fleeting presence, so as not to be mistaken for a dream. For as my eyes fill with the soft darkening sky, I notice the tracings of two ravens perched in the branches of a tall cedar, reaching for the sky. And it causes me to contemplate, vicariously, the view before them as they fly toward the flowing river. As I observe them swoop out of view, they leave me to imagine the bears' glutinous feasting. It was something that caused me to smile, at knowing the existence of such primal satisfaction, and of the magnificent razor-like claws swooping fish into mouths that are ravenous and opened wide.

In the recollection of the mystery of that extraordinary June day, I relive the pleasure those bears give me. I am aware of how they illuminate in my mind a reflexive relationship into my own form of living and life ways. It provokes me to consider the wilderness and its beauty as gifts, connections to a universe that assist us to make sense of life as it is lived. Such discoveries reveal the unexpected relationships we have with the world of living things, whereby something new in the present is always linked to something old in the past. Surprisingly, it becomes a resourceful dimension within us, keeping viable a quality of being resonant that assists us to recognize potential relationships with parallel sources of being.

It is also a location from where I view myself in the middle of a nested set of social life stories with people whom I share a personal, as well as a professional, life. For placing great importance on understanding and making meaning of our social experiences requires pilfering through the richness, nuance, and intricacy of many lived stories on different relational landscapes. It is a realization that assists us to relate to one another, with the desire to be connected in some way. And through our relatedness of thought and meaning, we come to understand and respect our interacting as powerful acts of intervening, some of which are paradigm-shifting and profound.

By experiencing the condition of belonging to something bigger than the self, such relational events help us to know new aspects of ourselves as integral parts of the experience itself. It is for this reason that I reflect on my own relational stories, narratives that appear different from each other, yet coalesce to form new pathways of relationship characteristic of a changing and dynamic life. For they are experiences from which not only acts of relational significance permeate all the events, happenings, attitudes, and feelings of the present, but also illuminate those I have discovered in the past and yet to discover in the future.

Within Hazel's shared conversations there, too, existed specific stories of a life where significance emerged in the lived relation she maintained with others. Profoundly, they included memories of tragedy and the loss of kinsfolk, which for Hazel had been sadly reawakened. For in them were memories of children, who Hazel had given life blood and brought into being. And they were conflicted memories filled with feelings of attachment and suffering that accompany the abrupt loss of close relations. Yet, amid such recollections and retellings was the discovery of diabetic narratives, whereby reflections of a diabetic life and its relational connections revealed an immediate richness of new meaning between story, strength, and wellbeing.

Lost Ones

~

Tragic Happenings

"I have a daughter and granddaughter who live in Williams Lake," Hazel explains. "They worry about me, because I've been sick. Sometimes they take me to the hospital, but I'm usually told everything seems okay and I just have to do this and that. I have two other really good granddaughters. They look after me, too. One of my daughters takes me to Vancouver when I have to go. She went with me when I had an operation in both eyes. They took the cataract off. She really understands me, and if I get sick I phone her. I'm okay right now, though. My blood sugars are not too far up, but I've had to learn a lot about diabetes. Sometimes I get invited to the health center so that I can learn about it. I usually go with my daughter who is a teacher."

"The last time we met for the diabetes was about this time last year," Hazel continues. "It was really good. I told them they should have people like that come more often so that they can explain things to us. We can learn from them and they can learn from us, too. I like that, because I didn't go through school. It was really hard for me. My parents died and my Auntie raised me up. She was married to a really nice man who had three children, two boys and a girl. Then there was me. My Auntie had just one child and liked children, so they ended up adopting five of us. My Auntie died many years ago in the seventies and my adopted father died shortly after that."

"A long time ago I was told my real Dad used to log by hand," Hazel recalls. "They didn't use a machine. He was one of the people who would go to Ocean Falls to get paid. That is where my Mom and Dad picked up the logs, too. My mother was 'expecting' me, so my Auntie went along, too. Once they were there they decided to celebrate the finishing of logging at the hotel, but she said to her sister, 'I feel like I'm going to have my baby.' There was a hospital there, but she didn't want to go to it. So she ended up having me on the boat! There was a lady on board who helped to deliver me. Long ago they would do this sort of thing, because there were no doctors. I say to my children, 'If I die just put me down in some water." Hazel laughs, her sense of humor showing through.

"So I was born on a boat, but I've lived in Bella Coola all my life," Hazel reminisces. "We lived across the river on the north side before the Necleetsconnay River flooded the village in 1934. Mom was Nuxalk and from there. My Dad really came from the other side of the river. So I was raised where the old village used to be until I was married. In those days they married the daughters at about age 13, because they were ashamed of them if they had babies without being together with a man. That is how they were and that is how my Auntie was with me. While I didn't expect to get married, I was trying not to get married too quickly, because I was too young. I was 15 when I got together with my husband. We were together until he died about 12 years ago. We had lots of children. There was no birth control then, and we didn't go to school. So we lived together and helped each other out. My husband's mother was a queen, the daughter of a Chief. So my children come from a large traditional Chief's family. And my husband's father gathered people from all along the coast. That is the way they used to do it long ago."

"I had 17 children all together," Hazel reveals. "During my last birth I couldn't push. I just relaxed and the doctor put me to sleep. I remember them asking me after if they could do anything for me, but they couldn't. In those days a woman had to have something wrong with her before she could have her tubes tied. Today it is good, because there are different kinds of birth control to choose from. It was later on in the summer that they operated on me. I was to have no more children. The doctor told me that I wasn't going to live the next time I had a baby. It was either the baby or me that was not going to live. So I let them operate."

"I don't know how I looked after so many children," Hazel recollects. "I didn't even have help. Some people tried to adopt our children. 'No,' I would always say to them. 'Make your own children.' I would never let my children go. God gave them to me and I loved them.' I have lost about six of them now, both as babies and adults. One of my sons drowned down by the wharf. He used to go logging and the alcohol got the best of him. I was working in the hospital at the time. I worked there for about 13 ½ years as a dishwasher. I loved it! I would meet people who I didn't know and made many friends. I remember how the young doctors used to come up to my house and make themselves at home. They used to call me, 'Mom.' They would ask, 'How is my Mom today?'"

"I think about my son sometimes, and how he fell off the boat into the water," Hazel recalls. "I was almost finished in the hospital for the day when my daughter phoned me. 'Better come home, Mom.' she said. I was finishing up the supper dishes and still had to clean up the kitchen. 'Oh, pretty soon now I'll be finished. Then I'll be home," I replied. My husband had called up a person we knew who used to be a minister in the Pentecostal Church. They came and picked me up. So I went home and when I saw my cousin sitting there I burst into tears. I was told what happened. For about three days I felt like I didn't know anything. It was a really sad day for me. I didn't remember much, except for that minister. She was a lady minister who stayed with me for a few days. She would go home at night and come back the next morning. After awhile I began 'picking up'. People were coming over to the house to visit and talk with me. They finally found him in the water, caught in some wire. It was good to find him."

"I lost another son who was logging down in South Bentinek. He got lost and they never found him," Hazel explains. "I'm not sure what really happened. I think he got sick. For two or three weeks after I tried to look for him, but there was no sign. No one was able to find him. That was hard for me, too. "

"I lost a daughter in a house fire along with two children," Hazel continues. "One child was two years old. It was our own house, but we were living in the house next to it. We left it for her and the kids to live in, because there had been too many people in just the one house. We think someone must have been cooking with grease, left it on the stove and went to sleep. The grease probably went all over the stove and started a fire. It happened in December on her birthday. They were all put together into a coffin, the babies, too. It took me more than eight years before I began to forget. At times I still miss them."

"All the deaths had to do with alcohol. My husband and I used to be in alcohol a long time ago, but we got turned around almost 50 years ago now," Hazel reveals. "My husband had bad arthritis in his knees. He used to be a logger and would work all summer until Christmas. Nothing made them stop logging, but he got to a point where he couldn't walk. So I talked to him about a Pentecostal priest up in Williams Lake who had a tent. My husband didn't want to go see him, but I said, 'You'd better go. He might do something for your knees.'"

"So he went with some people who were driving up there to see the priest," Hazel explains. "I didn't go because the car was too crowded. When he came back three days later he said he got healed. 'Honest to goodness, Hazel! I got healed,' he said. He used to like to whistle, especially when he worked. When he got back it was really nice to hear him whistle. And around that same time there was one afternoon when he became really tired. I remember how he sat down in his chair in the old house. It was the house that burned down. He was sitting next to the window. We were listening to the radio and I was knitting. As I watched him, he turned his face around and looked at me. There was something there that touched my heart. It was just like a rainbow over his head. I said to him, 'Oh, that healing is working for you.' That's what made me think about the alcohol. I said to myself, 'If he quits, I'll quit with him.' I knew if I drank at all, he might follow me back to his own drinking. I was thinking about this very hard. And I was in the kitchen cooking for the family. Then, my husband got up and walked to the kitchen. I knew he felt different. He wasn't walking the same. 'Are you alright?' I asked him. 'Oh, yes! I can't believe how much my knees have changed,' he replied."

"The doctor wanted to see him the next month," Hazel continues. "I was working at the hospital and he says, 'How is your husband?' 'Oh, he's doing really well. He's even gone back to work,' I replied. The doctor didn't believe it. He asks, 'Is that true? Okay, I would like you to bring him down after he has eaten. I'm going to wait for him here at the hospital. I want to see his knee. I want him to prove to me that it's better.' So after I returned home I told my husband, 'Go see that doctor after you've had supper. And don't say no, just go and see him. He can't believe you've been working with your troubled knee.'"

"So my husband went to see the doctor and I guess he was really pleased, because he was in there for quite awhile," Hazel reveals. "After my husband told him what had happened, the doctor seemed to think that there was really something to it. He was convinced that my husband was walking like he used to walk before. And I remember how after my husband had seen the priest, we had a talk. I said to my husband, 'We both need to quit the alcohol. If I go on the alcohol, maybe, you will follow me, but I'm not going to do that. I'm going to help you and stick with you.'" He replied, 'We promised that when we got married it was for better or worse'. So we went along with each other. 7 We didn't drink again. He kept working for about another 40 years, up until he started having heart problems. It was then that he had to quit work. He died of a heart attack about 12 years ago. It makes me think that we had our problems, but we loved each other, too. I didn't know what to do when I lost him, but I knew we had each other in our hearts."

A Carved Spoon

~

Sustained Connections

"I like to tell my children, Sylvia, that if I had gone through school, maybe, I could have written about Bella Coola and how it was to grow up here," Hazel explains. "Everyone had to move from one side of the river to the other, because the floods washed out the roads and bridges. The hospital and school were on the other side. So they had to move us. I remember how they tried to dig a well over there, but the older people got sick. That's really why they had to move us to this side of the river in 1937."

"They had to move our old church, too," Hazel continues. "I remember how we watched these two men coming with big machines, but they finally got the church over to the other side of the river. That church used to remind me of the brass music band our people used to have. It always played for someone who had died. When I was a little girl I used to cry, because they played such sad songs. It was at Christmas time when I really liked to hear them play. The music lifted our hearts."

"I also remember not being able to go to school," Hazel reveals. "My adopted dad used to hemorrhage, so they had to send him to the hospital in Bella Bella. He stayed there for almost three years, trying to heal up. And that was why I hardly went to school, because he couldn't work. He couldn't lift heavy things. So we'd go along with him to trap. I wanted to go to school, but there was no one who could look after us. That's just the way it was, but there was one time they tried to put me in school. I was young, about seven or eight years old. The person who looked after the school was a Catholic, and there was a little room where we would sit when they brought us in. They wanted my dad to leave me there. I remember how I used to hold on to his leg so that he wouldn't leave. 'Don't leave me Dad,' I'd say to him. They stayed home from trapping for two weeks until I was alright, but it was just a brief time at the school."

"My adopted parents taught me really good manners," Hazel recalls. "They taught me how to be clean and how to cook. They taught me everything. I remember them teaching me how to cut fish, too. I was about 11 years old and I would help my mom cut fish. Sometimes I cried, because we were always going to check the net in the river. We'd pull it out of the river and put it in the canoe. They used canoes all the time in those days. When the fish were ready to cut, we would pack them up in a wheelbarrow to the house. And when we cut them up and put them in the smokehouse, I learned all sorts of things from them. Our parents were good, because they taught us what to do. I thought about them a lot when I got married, because my mom would say to me when I was young, 'Okay, stop crying. You have to learn what to do, because you'll get married when you get older.' She was a really nice mom. I always called her my Mom. It made me sad that she died from alcohol. When the liquor store first came here, she couldn't stop."

"And my adopted dad went blind when he was older," Hazel explains. "He used to carve bracelets, rings, and earrings. He carved totem poles, too. That's how he made a little money. I still have a spoon that he made me. It was the last thing he gave me before he died." Hazel takes a deep breath to pause. "They had operated on his eyes, so he could see quite well, but he really couldn't do much anymore. I remember how I used to go and check on him when my auntie was into the alcohol. She died with it. It made me think about the times when I was young, and how they used to drink homemade wine. I couldn't sleep at night, because of all the noise. And I remember thinking to myself, 'I don't think I'll be like that. I don't want to be like that.' I didn't drink alcohol until I met my husband. He was already into it, because his dad would drink, too."

"My husband was really good with the family," Hazel continues. "Sometimes he'd tell me not to cook and do the cooking. He did that when he wasn't working. He was alright that way. We had our hard times and argued, but I told him, 'Just forget about it. If you die I don't think I'll marry again. I'd be lucky to find somebody to love our children, because some men don't like step-children. I saw that, because my adopted dad was married before. He would say to me, 'It's really hard to have trouble with your husband, but try to stick with him for the children's sake.' That's the way he was. My adopted parents taught me well. They taught me how to love people. We don't have to be anyone's enemy. We come from the same place, but come with different colors. That's the way they brought us up. And if anybody was hungry, we fed them. That's the way we were taught to be. There were many young people who used to come to our house, and we would help them all. We didn't want to see anybody starve. Our parents showed us how to love one another."

"There have been times when children we knew were in trouble," Hazel reveals. "They would come to us and ask for help. I would say to them, 'We would love to help you.' I said that because I had been one to need help, too. I had no parents, sisters, and brothers. So I helped a lot of young people. Even when I was working in the hospital, I was taking time with some of the elders, too. I find that it's really good for me, now, because some ladies go back to drinking when their husband dies, but not me. I just go right on with my children. They are the ones who come first. I never put them down, I put them first."

"There are nine children in my life, now," Hazel explains. "My youngest is 43. I always tell them, 'Don't hate anybody. Just love them, even if you get hurt. Just try and forget what they did. We don't get anywhere if we hate somebody. We need to love one another and help people who need help. That's the way I've lived my life. I was a homemaker and liked to help the older people. I have a great-aunt. When she was in a wheelchair I used to clean up for her. She just loved dogs. Her dog was like her baby, because she didn't have any children. She did have one, but he died."

"When I was growing up and helping these older people, it made me think," Hazel continues. "If I had gone to school, I would have liked to of taken nursing. It would have been helpful to be a nurse that spoke our language. I had been asked to do that a few times in the old hospital by the doctors. There were always older people who couldn't speak English, so I helped them. They'd tell me where it hurt and I'd pass it on to the doctor for them. Nursing is what I wanted for myself, but like I said, I couldn't make it to school."

"You went to school in a different way, Hazel, because you learned so much from your adoptive parents," I indicate. "That's what I was told when our people asked me to teach in the Indian language class. If the way they were pronouncing it wasn't right, they asked me to correct it," Hazel responds. "They benefited so much from your ability to speak the language," I emphasize. "Yes, that's what they say to me, even though I didn't finish school," she reveals. I return the smile that is lighting up Hazel's kind face.

Sweet Marshmallows

~

Trying to Control Myself

"I've had diabetes for about 20 years," Hazel explains. "One of the first things I remember at the diabetic classes in Vancouver was learning with the plastic food about food portions and how to eat. They asked me if I wanted to use insulin. I said, 'Oh no! I don't like needles. I'll try the pills.' It was a time when I couldn't stop eating and so my blood sugar went way up. It turned out to be a lucky thing, because I felt as if I had lost my mind. They kept me for a couple of days in the hospital until it went down. I'm all right now. I control myself with pills. When I first found out I was diabetic, though, I would see them every six months. They'd tell me, 'Take a walk. You need to walk all the time.' So I used to walk around the village every day, except when there was snow on the ground."

"I was really angry at myself about having diabetes," Hazel continues. "I'm going to tell you something. I liked marshmallows! When I tasted one I couldn't help but eat more. It cost me, because I was weak. I blamed myself for it. While I didn't know much about being diabetic, I did find some things out by working in the hospital. I knew that diabetic people got certain food, but I didn't want to cut out the things I enjoyed. For a long time I had to learn how to watch myself. My son helped me a lot, and still does."

"In those early years I found it hard to adjust to the diabetes, because we didn't know what the sickness was and we didn't go to the hospital much," Hazel reveals. "We were healthy. When I first heard about diabetes it was because a few of our people had it. I always wondered what caused the blood sugar to go so high. After I got diabetes, I had to learn about what all the sweet things did to us. When I went to the Vancouver diabetes classes, they told us what to eat. 'Eat the fruit in cans with no sugar in it,' they said. They spent hours telling us what to eat. I remember being told to have just one egg in the morning and one piece of toast, eat a little between meals, and take a piece of fruit if you get hungry. That's what I learnt when I first started being diabetic. And I remember how I would hide myself from my family sometimes. I didn't want them to see what I was eating, but they saw me and helped me along. One of my granddaughters helps me a lot. She gets me natural things, like whole wheat rolls and organic fruit. And she tells me to drink lots of water. I like how she reminds me what to do. She really loves her granny!"

"Over the years it has helped me when people I trust tell me what to do and what not to do, because it is easy to forget," Hazel recalls. "It's hard to control the diabetes, but I'm really thankful there is something to take for it! I would be in the hospital if I didn't have the diabetic pills."

"I try to have lots of vegetables and diabetic things, but when I get invited out it's really hard to control myself," Hazel explains. "If somebody watches me I can control myself better, but it's still hard. I keep telling myself, 'Control your self!' I still need to lose weight, but I can't seem to lose it. I have to start walking again. And when I get invited out, I have to stick to fish and rice. I shouldn't eat much of the potatoes, but I love potatoes! So I try to have more vegetables. My son always tells me that, so I cook a lot of vegetables. Then I will just pick at them later, eating them if I feel hungry."

"There are Indian medicines that are supposed to be good for diabetes," Hazel continues. "Our people are learning about them and they tell me. There is one plant that is good for diabetics. So I've tried it. I'm willing to try everything. I remember one time I got sick and my daughter took me to the hospital. The doctor checked me out and said, 'Everything is all right with your heart. Your breathing and blood pressure are all right, too.' Everything was okay with me, except for my stomach. So I went home and my daughter asked the woman who makes our Indian medicine if she would make me some more. I took a tablespoon and found it really soothed my aching stomach."

"I didn't go by what she said to do," Hazel reveals. "I was supposed to take just a few drops of it to start, but I took a tablespoon. I phoned my daughter and said, 'Our friend is a good doctor. I feel good now with that medicine!' But I know it's mostly me. My stomach hurts when I don't control what I eat, especially if I eat sweets, but I keep trying. I need to try harder again and eat just a little bit. I think I'm getting too heavy for my knees, but I can still walk. I have a washing machine in the basement, so I go up and down the stairs. If I don't get out and walk because the weather is bad, they told me to walk around inside, but I try and get outside."

"Just the other day my blood sugar went up to seventeen," Hazel recalls. "I blame myself, because I ate too many sweet things. I like to eat dried fruit, like prunes. My daughter gave me a bag that was all natural, but I ate too many at one time. They are rich and sweet, too. If I could control myself better, I'd be all right. Then I wouldn't have to work at getting my blood sugar down. Once in a while I get it right down to four, but most of the time I'm at nine or ten. When it's too high I feel tired and sleepy."

"The diabetes has made me think about how our family always had lots to eat when we were growing up. We didn't buy anything from the store like we do today, only sacks of flour, rice, and sugar. We ate wild foods and canned a lot. We never limited ourselves to food. I suppose we got used to eating too much. If we did not eat, we believed we would get sick. I remember our parents telling us, 'Eat your food. It will make you strong.' I always believed it was healthy to eat a lot. It was different in other ways, too. Everything was so much cheaper. I was telling my children how we used to buy running shoes for 25 cents. Today you can buy runners that cost 200 dollars. We used to wear shoes that were heavy and lasted a long time. I remember one time my mom bought me a pair of shoes from the store that had a higher heel than usual. She bought those shoes without asking me what size I was, but they fit when I put them on. I put them on upstairs in our room and when I came down my heels got caught in the cracks. It was Sunday and we were all going to church. So I took my shoes off in the little kitchen at the bottom of the stairs and I burned them. Mom asked me later, 'Where are the shoes I bought you?' I couldn't tell her what I did. It was only later that I opened up and told her. She could have been mad at me, but she just smiled. I'll never forget that."

Potlatches

Looking After Each Other

"I saw my niece the other day," Hazel explains. "She is living just across the street from us now. She really took to me and always says she loves her auntie. I tell her that I'm really proud of how she looked after her grandmother. 'You are the only one that was the best with her,' I tell her. She stayed with granny for almost two years before she passed away. She likes looking after me, too."

"When we lose our loved ones, we have a potlatch," Hazel continues. "I remember when they had one for her grandmother. I got up and spoke. I really thanked my niece for looking after her granny, because she was such a young girl. And I told her that it was her granny who was now thanking her, too. Many young people don't want to look after the elders when they get old, but she was different. I remember the time she phoned me to ask if I would knit a pair of slippers for her grandmother. She said, 'Don't tell her. I'm going to give them to her for Christmas.' She was pleased with herself for doing this."

"When spring came her grandmother died," Hazel reveals. "I had to tell the family not to put anything that was handmade in her final resting place. The old people told us that it was not a good thing to do. They had traditions for these things. They said that if this was done, you would become forgetful. So you didn't want to do it. When a person is put in a coffin, money is placed in their hand, like a five dollar bill. The family always puts new clothes on the person as well. It is because she will be resting there for a long time, until just the bones are there. And it's the bones that will come back to you. That is the way our ancestors understood it. We're not supposed to put our tears in the coffin, either. I often say to our people that if they open the coffin to see their loved one, not to cry and drop the tears onto them. That is just our way, and it has been a law with our people for centuries."

"My parents taught me some of the old ways," Hazel recalls. "They didn't go to school and so spoke their language all the time. That's why I know how to speak our language. I tell my children that I had a hard life when I was young, but a good life. We wanted to do things for our parents and we listened to them. We always did what they told us. We were home by nine o'clock every night, too. We didn't have streetlights, just gaslights. I remember using coal oil lamps at home, and candles before that. My mother was such a hard worker, even though she had a small frame. We were brought up the way they used to be brought up. We never stayed home much, because we loved to play outdoors. I remember how fun it was for me to go trapping with my dad. We met up with all sorts of wolves and bears. Grizzly and black bears are something to see! We learned from them, and that is the way our lives were. I loved those young years, and seeing those animals in the wild."

"A couple of years ago, one of my cousin's daughters had a son," Hazel explains. "I never saw this boy, but had seen them carrying him around. When he was almost two years old he suddenly got sick. They took him to the hospital and he died there. They called me to burn his belongings. Our ancestors from long ago burned things belonging to the person who died. When I die, I have told my children to burn some of my things, but that they can also keep whatever they want, too. I remember when the little boy had passed away. His family called me after he was buried and wanted me to 'smoke' what was to be kept. It was so that they would not be bothered by the spirits of the dead people. It is said that these spirits are all alive."

"I'll never forget what happened while the family was having their ceremony," Hazel continues. "There were lots of people around and we were all standing in a circle by the fire. I remember how we looked up to the sky and saw eagles. They circled four times around our tower of smoke. As we looked up and wondered what was going on, I thought of the eagles as taking the baby home. That is what I was thinking, because there were four of them. Just before we finished, about 20 geese flew over us. They circled two times above us, flying in the shape of a 'v'. I thought it was strange, too, because it was the first time I had ever seen geese do that. It was beautiful to watch. And it was a special day for the baby. I think quite a few people saw what was happening. They asked me about it afterward. I said, 'I think the little boy is a really good spirit.' His mother had twin girls after that."

"In the old days, animals had all kinds of meanings," Hazel recalls. "The crow that is better known to us as the raven would always go around 'cawing'. When something was wrong, the raven would always come around and 'caw', sounding very sad. My dad would say, 'Oh, something bad is happening in Bella Coola. Somebody is sick or has died.' Two or three days later we would find out that something did happen. And if the raven's 'caw' sounded happy, it meant that somebody was coming. So it wasn't always a sad thing. The raven is just like a messenger. It is like they go all over the world. And it's a story within our tribe about the worlds. He's is a reporter. That is what our people used to say. The raven tells you what is going on."

And with Hazel's words, I thought about the importance that awaits each one of us in *all our relations.*

Bannock and Tea

~

Relational Secrets

"There is a lot to know about what the land and animals are always giving us," Hazel explains. "Today we depend on the store for our food, and there was even a law here not to shoot deer for a while. The government tried to do that with the fish, too, but we fought against it. It has been our food for generations. We've always eaten all kinds of fish and shellfish. I remember how we would spread all the clams out in the sun, and if it was raining we'd put them inside the smokehouse. Mom used to show me what to do. We'd clean the outside of the clams and steam them, and stick about six cedar sticks through each fish. We would make strings of fish about four feet wide and six feet long. They'd dry out so well in the sun."

"My mother used to trade food," Hazel continues. "We never sold it. The people from Bella Bella used to do that, too. They would arrive to trade what they had with the people of Bella Coola. We would trade dried fish and oolighan grease for clams, but for the last three years the oolighan haven't been running. We miss that grease, because we not only cook with it but it's a medicine, too. It's real good for your health. Mom used it when we had colds and sore throats. She'd use a little dish to warm the grease and give us half a teaspoon four times a day. And sometimes she'd soak an old cloth or sweater and put it on our chests that way."

"We hope the oolighan comes back," Hazel reveals. "It reminds me of the people living on both sides of the river. They'd holler to each other, 'How's your grease?'" Hazel laughs. "There was a time when my husband's parents were on the other side of the river from us. We would hear his father holler across the river in a really loud voice. Then we'd go visit them all day and bring food. Mom would mix flour, baking powder, and a little salt and water together. She'd add some grease to it and cook it on the frying pan. We call it 'bannock'. People would smell it cooking and come over and have it with tea. We don't use the oolighan grease much today. We usually avoid it. When the grease is used it's in the smokehouse or on the fire pit. It's better to cook with it outside, because of its strong smell."

"A long time ago I remember my cousin was sick with tuberculosis," Hazel recalls. "He was living with us and Mom got some fat from the stomach of a deer. It's just like cheesecloth. She had dried it and kept some in case we needed it. She warmed it in a frying pan until it was melted. Then she took the gum of a particular tree. It was dry and had to be melted, too. I remember how it can't be over cooked, otherwise, it's no good to use. Mom always did it just right and mixed it with the oolighan grease. It was then ready to be rolled out in little bits. They looked just like pills. I used to help her roll them. I remember Mom giving them to our cousin. His family didn't take him to the hospital, but he took them and got better."

"I got really sick once when I was about seven years old," Hazel explains. "I was so weak that I couldn't lift a spoon. I was really thin and my parents had to carry me to the bathroom. I don't know what made me sick, because we didn't go to see the doctor in Bella Coola. My parents collected medicine from a particular tree, boiled it, and let it simmer all day. Mom gave me a little bit in a cup. It was like a laxative and cleaned me right out. I remember the first thing I wanted to eat after were eggs. My appetite came back and it didn't take long before I turned into a chubby little girl. I think that's why I'm here today, because it was really good Indian medicine. Years later the doctor saw something on my lung with the x-ray. He says to me, 'You have a spot here that looks like you had TB once.'"

"I remember being given a lot of different kinds of traditional medicine," Hazel reveals. "There were ones that were often used, because they brought people's energy back. The other sickness was measles. All my children had it. And they were sick from chicken pox, too. That is how my real mom died. She died from measles. I was 12 months old at the time and she was in the hospital. Before she died, she told the lady in the room with her, 'Please, will you keep an eye on my daughter.' I wasn't told about this until later when I was much older and had children. This lady became real sick and I went over to see her. She grabbed my hands and said in our language, 'I have wanted to tell you what your mom said to me. She told me to keep an eye on you, her daughter.' I cried. I couldn't help it. I replied, 'Why didn't you tell me this before?' I cried some more and she cried with me. She said she was sorry that she hadn't told me earlier. I thanked her for telling me, because it helped me to know my real mom more. I was so young when she died. When I was a little older and growing up, I dreamt about what my real mother and father might of been like. I wanted to know them. There were eight of us in the family, but they all died except for me. That is the way my life went."

Being With People

~

Love in the Heart

"Years ago we didn't have refrigerators to store food in," Hazel explains. "So people used a lot of salt. They salted up the spring salmon real thick. It was really hard for those people with diabetes to control themselves and eat what they were supposed to. They didn't understand what the doctors meant, because they didn't speak the White language. They were worse off than we are today, because they didn't go to school at all. Many lost their legs and died from diabetes. We tried to help them understand what sugar diabetes was about, but they couldn't stop eating what they were used to. It just got worse and worse for them. The doctors kept explaining it to them, but they kept eating sweet things."

"When I went to the four Vancouver diabetes workshops to learn about diabetes, it was after that that I learned what not to eat," Hazel continues. "That was important for me, because I was able to take in more. I listened to why we shouldn't eat sweet canned foods, butter, and so many other things. Today I still see people taking lots of the baking and sweets home. I take some, too, but remove the icing on it if I decide to eat it. And I don't put icing on cakes if I bake them. I remember being told by the workshop people to eat just a small piece of cake if we have to, like when somebody invites us out. So I try and help other people with diabetes as much as I can, especially the people who really need it."

"I have a lot of love in my heart," Hazel reveals. "So I help people with whatever their needs may be. That is the way my children are with other people, too. Sometimes they ask me, 'How come you are like that?' So then we talk. I was really surprised when my son first started living alone. He surprised me one day by saying how he had been talking with some 'white' kids. He has lots of friends. Even the little kids outside where he works ask him to sit down with them and talk. They tell him what is going on in their lives and my son listens. They ask, 'How come you are like this? We are 'white' people and you are Indian.' And he tells them, 'My parents brought us up this way. We don't have to hate anyone. We have to feed people who can't afford anything. We bring them in and feed them.' And he goes on to say, 'Don't hate your parents. Go home and talk with them. Tell them what you're feeling. They will talk with you.' Some of those children are doing all right now. And some of them have divorced parents and don't know what to do. He's just like a counselor. He keeps on surprising me, too. I'm so proud of him that he makes me cry, because I'm so happy."

"When my husband and I first got together, we didn't have our own home," Hazel recalls. "We used to live with our parents. It was hard for us. We stayed with my grandmother for a couple of months and then with my husband's parents a few times. Later my mom and dad gave us our first house. I can remember almost leaving my husband several times. Our parents got us back together. They said, 'Do it for your children.' I felt really loved as a daughter by my adopted dad. When we had children and moved to a new house, I always looked after him. I tried to pay back what my parents did for me. And I tried to look after them when they got older. Even though I had children, I always told my husband, 'don't mind me if I look in on my parents, because they raised me. I wouldn't be here if it wasn't for them.' So I always went over to check on them."

"That is one nice thing about our people," Hazel explains. "We help each other. When somebody dies in the hospital we all go to pay our respects. We don't forget each other, but hang on to each other. And when people are sick at home we visit them. We try and lift their spirits so they don't feel too bad. That is the way we are in Bella Coola. I know some 'white' people who are friendly to us. And when something has happened to them I've gone to see them in the hospital. Some people say to me, 'Oh, they are 'white' people, never mind.' But I like to go and see them, because in many ways they're not any different from us."

"I remember going to talk to one young boy with diabetes years ago," Hazel continues. "He's grown up now, but at the time he was behaving real badly in school. The elders were asked to go and talk to him about school. He was a spoiled boy. He used to fight with the teacher, too. I said to him, 'You better smarten up. I'm related to you and I love you! You are my cousin. Listen to your mom. Listen to your teacher. Listen to your dad. And listen to your elders. Learn to be a good person. Do this for yourself, not for anybody else. When you finish school you might want to do something with your education, something other than what you're doing now, and you'll be able to. It would be nice for you. You could then help other people like us and other kids like yourself.' I asked his mom later, 'How is your son doing, now that the elders talked with him?' She replied, 'I think he listened, because he's doing better.'"

"I didn't get mad at him," Hazel reveals. "I just talked to him. Today the children are so much better off than we used to be. It's really good for the children here. They are lucky they can stay in town and go to school right here in Bella Coola. I think it's natural for young people to get confused in their thinking. I was that way when I was young. So they make me sit down and think about things. That's why I help at the Native language school. I was scared to do it at first. I thought that it might not be of any help to anyone, but after they asked me, 'Are you coming again next year, Hazel?' I said, 'Oh yes, if you want me.'"

"I had to find my own way many times during my life," Hazel explains. "I didn't have to depend on others too much, but now that my blood sugars go high sometimes, I depend on others more. There are all sorts of people who have helped me. My son helps me out a lot now. I tell him, 'I haven't been walking this week.' He then reminds me to go and walk. I'll go to a couple of different stores and then return home. The walks really do help my blood sugar, and if nothing else it gives me a chance to buy some baby wool for knitting and crocheting." Hazel grins.

Listening to the Health People

"When I was young and lived across the river we never had sweets," Hazel explains. "We had apples and oranges, and some people grew pears. I really liked pears and apricots, but the only candy we'd sometimes get were pieces of chocolate rolled in paper. Later on the pop came. I remember one of my husband's fishermen friends. They would call each other to go and eat together. This fellow would never drink tea or coffee. The first thing in the morning he had was pop, and when he went fishing he took along cases of it. He died with diabetes. The doctors tried to tell him what diabetes was, but he never listened."

"It makes me remember when we didn't have phones," Hazel continues. "It was before the new hospital was built. We'd go as a group to see the doctor, or they'd tell us to all come at a certain time, especially if our children were sick. One day we were sitting with our children, some in buggies, in the waiting room. A lady was sitting there holding her crying baby. She took the nipple from the baby bottle and placed it in an Orange Crush bottle. Then she gave it to that wee baby who started crying again. The doctor came out and saw this baby with the Orange Crush and got really mad at her. He took the bottle, picked up the baby, and said, 'You're not supposed to give this to a little one! It's for a big person, not a baby!' The mother got mad. I went up to her and said, 'You should listen to the doctor. You don't know what's in that pop. It's Orange Crush all right, and it's from orange, but maybe something is mixed with it. It's all right if you give your baby orange juice or apple juice.' She felt better. Then we all waited there most of the day with our babies. I was glad she listened to me. In those days we didn't drink anything like pop. She just didn't know it was full of sugar."

"As time passed we saw the doctors more," Hazel recalls. "I remember a time when I was sick and my husband had to take one of our children to see the doctor. He told my husband, 'You're the only people here who have healthy kids. You don't seem to need to bring them here very often. It seems like most people are bringing their children here to be looked after in the hospital. You come with your children only if they're sick and then you take them home.' Other times I would say to the doctor, 'If my child doesn't need to be in the hospital, just give me the medicine and I'll look after him.' I never wanted to leave them there and have to depend on the doctors and nurses. I always depended on myself, because it was my child. I thought that most of the doctors were all right. They would always give me the medicine and I would go home. If my child got worse, I knew to bring him back."

"I always looked after my own children," Hazel reveals. "I never wanted them to get sick. One doctor told me that he belonged to a large family and how his mother used to bake lots of bread. She would let the kids eat as much as they needed when they were hungry. She told him to eat so that he wouldn't get sick. If he had an empty stomach he might get sick. I listened to that doctor and cooked lots of potato and ooligan for my family. We put everything on the table and the children would go ahead and eat. We'd have to tell them not to be fussy. I think that's why our kids were healthy."

"We had lots of other things to eat, too, because we traded things like dried moose meat and fish," Hazel explains. "I grew up with lots of food. When I first got diabetes they told me not to eat too much dried fish. 'Just take two sticks,' they told me. It was really hard for me to do that, but I tried. I got sick eating too much dried fish a few times so I quit eating it for a while. I'm starting to eat a little bit of it now. I use the water I boil the fish in, put onions in there, and then drink a little bit. I don't get sick from that, but the ooligan grease I love. When I taste it I can't help but eat it. I get sick with it, too, because it's too rich for me now. Once I told my kids I was testing myself by having just a little bit. I wanted to see if it would bother me, but I got sick for three days with a real bad stomachache. I just couldn't stop eating the grease."

"Years ago our people used to eat grease most of the time with their food," Hazel continues. "If they made a fish stew with Dog Salmon, they'd put one or two tablespoons of grease in it. And if they boiled Coho or Humpback salmon, they'd do the same. We really liked it. It would be used to trade with the Bella Bella people for seaweed and herring eggs. They used to dry the herring eggs, hang them up in the trees to dry, and put them away for winter. I remember when they'd come and trade in Bella Coola. We'd eat those dried herring eggs for lunch and sometimes with grease and potatoes. It was a delicious treat!"

"It reminds me how a long time ago our people would eat seal meat," Hazel recollects. "The seals were important to the Chiefs. If a person caught one he 'fixed it up' and the skin would be burned. Then the seal was cut up and the first piece given to the Chief. Seal was just important to the people, too. The meat would be boiled and eaten with dried fish. The same was done with the first Spring salmon that was caught. The line would be put in the river with a feather and the Chiefs would get the first taste. Then everybody would eat. They didn't waste much of the fish, either, just the guts. The heads and tails were always cooked and eaten. Sometimes they cooked the liver and the heart, too. Today, if someone throws part of the fish away that is supposed to be kept, they'll hear about it. We learned not to waste anything!"

"Our ancestors would make boxes to store the food in," Hazel continues. "They used pitch from the trees, melted it, and would put a really thin layer over the box. It was made really tight with ties before they coated it. When it was all stuck together it was just like glue. Then they'd take the bottom and top off and make another one. It was made really thick inside so nothing could get in there like flies or mice. When the box was bone dry they'd hang fish skins in there. That made it really dry. Our people who made those boxes believed that by putting dried fish in them, the other stored food wouldn't get eaten. It's what they did so that they wouldn't be the ones to go hungry. They were also able to share the food with people who didn't have any. That is why they all lived. It was believed that if they didn't make boxes that way and follow traditional ways, their family might die. It could cause all sorts of mishaps to take place, such as not being able to find the food boxes or the food being eaten by animals. That is the way we were told the story and why they always told us not to be stingy with anybody. Even if the person doesn't do anything for you, share with them. Our ancestors shared everything with each other. Once they shared, they considered everything to be all right – food boxes would never be lost or be tampered with by wild animals."

"This week the community is going to have a salmon ceremony," Hazel reveals. "It's all about the Spring salmon and it's going to be held in the hall. "We're trying to follow more of the ways of our people from long ago. Everyone is invited to come and watch the feather being placed around the salmon. There will even be Indian dancing. And every part of the fish that isn't used will be taken back to the water - returned to the land. That is the way our ancestors did it and so that is what we are doing today. They are going to barbecue the fish and serve it to everyone. We'll bring whatever we have to share so that there will be lots of potatoes and vegetables to go with the fish. We do this every year. All the Chiefs are going to be there and all the elders and young people, too. Everyone is welcome!"

Thunderbird Dance

~

Helping Each Other

"There was a lady who got sick in our village," Hazel explains. "We almost lost her. She was diabetic and always looked after the elders at Christmas. She was a really generous person. She was from out of town, but liked living in Bella Coola. She used to work in the hospital and talk about her diabetes with others. They had regular meetings about it. Once in a while the health people working in Williams Lake would come down, too. I went to about three of the meetings that were held at the clinic. One time I remember how we were all sitting in a circle and told to look at our shoes. At first we didn't know what we were looking at. We were asked, 'Do you see Hazel's shoes and socks?' The clinic lady said that because they tell diabetics to wear special shoes and socks. The shoes shouldn't be tight and the elastic on the socks not tight, either. Then she said, 'Hazel's shoes are number one because they lace up.' The lady who was sitting beside me was wearing only sandals. She didn't use socks and that was a danger, because we learned that if you drop something on your foot and injure it, you might get an infection."

"They also taught us about looking after cuts on the skin when you're a diabetic," Hazel continues. "We have to look after them. A lady we knew who lost her leg talked about how she didn't want them to take it, but knew they had to because of the infection. Her family finally got her to go to the hospital. She's 90 years old now and is still doing all right, living down by the riverbank. I remember when she came to my son's birthday. He always invited the elders. Her husband had taught my son the Thunderbird dance so that it could be kept alive. More young kids are learning to dance it, too. It's really wonderful to watch!"

"The elders are planning to take a trip down south this summer," Hazel reveals. We'll gather together on the first day and march in with traditional dress. The Chiefs will be in their traditional dress, too. They will call out where they come from, because they will have traveled from all down the coast. I've been going to this event for the last three years now. It warms my heart to see everyone represent the places they come from. It honors who we are."

"Last night the community had a celebration to welcome the young people back," Hazel continues. They had gone to school outside Bella Coola and were presented with little gifts. It was important to recognize their accomplishments. It reminded me of how our ways have really changed. I was talking to a couple at the post office the other day. We sat down and started talking about the things from long ago. I said to my friend, 'These kids today. Some of them are lazy. When I was young I used to scrub the floor by hand.' This made us laugh. I told her that I had two adopted brothers and how I used to wash their jeans in a big tub on the porch of the house. My Dad had a long brush that I used on the pants which I placed flat in a tub of water. I remember Mom saying to me, 'what are you doing, Hazel?' 'I'm scrubbing my brother's pants. I have to scrub them in this big tub because they're so stiff,' I replied. That was the way my friends and I were talking and thinking back over the past. Now you can put your clothes in the washer and forget about them. A couple of hours later everything is done. And everyone uses a dryer now, even on a nice day. But I remember how during the winter we'd hang our clothes outside and they'd freeze on the line. They took days to dry. This sure kept the three of us laughing in front of the post office!"

"It makes me think about how we were more active then," Hazel recalls. "Maybe that is why fewer people had diabetes, because they worked until it was dark. On Sundays people didn't work. It was a day to relax and visit with each other. I remember a place straight up the road that we'd go on a Sunday. There would be tents set up and everybody went up there. It always seemed to be sunny and we'd tell each other all sorts of stories. I used to sit down and listen to them. The men and women would visit each other and talk. That is one thing that they were really good about doing on Sunday. People were good to each other and looked after each other. If somebody needed help they all pitched in. They didn't want to get paid. They just helped each other."

"My granny was one of those people who worked hard," Hazel reveals. "She worked in the cannery and mended nets. She had children, but they were grown up. They saved every bit they made to get the things they needed. Most people in those days worked hard. Maybe that's why they didn't have diabetes, because they worked so hard. If a person was sick, they went and helped. That's the way we were brought up. Help the people who need help and be kind. Don't be mean or fight with each other. That's what they would tell us, 'Love the people.' We were taught not to make enemies with anyone. I wish the world would turn that way now. There are places in the world with awful problems. There are people who are hungry and dying every day. I wish we had enough for everybody. I can't help but think that way sometimes."

My Indian Name

The Grace of an Elder

"I'm called on to do different things these days," Hazel explains. "They ask me, 'Would you come and give the opening and closing prayer at our community dinner? Would you come and talk to the kids?' I reply, 'Okay, I'll go.' I do it because some of the young people have turned into something that isn't nice. It's sad. There have been a lot of young people die here since the liquor store opened. One of my adopted brothers died with it. He went to sleep on the couch and never woke up. It was from too much alcohol. He was a nice boy. I think the drinking is slowing down now and the smoking, too. I think they find it costs too much, so both those things are slowing down a little bit."

"When I get out for a walk I sometimes sit down on the bank of the river. I like to watch the fishermen," Hazel continues. "Even if I don't see what they catch, it's nice to watch them. It makes me think about things that matter. It seems like our children are waking up to the ways of yesterday. They've returned to the traditional dances and some of the ceremonies. I tell them that it's important to learn to pray, 'If you want something to happen, pray,' I tell them to pray by blessing the food and pray to the Creator for somebody they are concerned about. I tell them they have got to learn the old ways, because the elders are not going to be here much longer. I try to tell them that, especially when I go to the Native language class. 'You've got to learn how to pray, even if it's just two or three words. It will help.'"

"There are two young girls who really know the language," Hazel reveals. "They're so good at it that they never forget what they're saying. One of them graduated from school last week. She's teaching her niece to talk with her. I noticed her doing that and smiled at her. 'Good for you for teaching this young girl our language,' I said to her. She was nervous, but did just fine. I told her that when we first do something we are nervous. We are scared to speak. I was that way when I first started, but after my husband died the people turned to me. They used to ask my husband for these things. He would pray for the people and pray for lost ones. I listened to him when he spoke. When there was a little trouble for somebody, he made the family circle. We held each other's hands and prayed. It was good learning for our children, too. When he passed on, that is what I continued doing for my children and other people. It surprised me that people would say, 'You want to do this for us?'"

"One time there was a minister here who asked me to go up to the valley with her," Hazel recalls. "She was gathering people together from all different faiths and I asked her if I could say a prayer in my language. I was the last one to speak. I remembered as I prayed, it was if someone was telling me what to say. It felt so easy. I spoke for about fifteen minutes and after I finished, three ladies came over to me. They said, 'We seemed to understand what you were speaking about, even if it was your language. We wanted to thank you.' They looked like they were about to cry. I replied, 'Thank you, thank you from my heart. I'm scared that I might say the wrong words, even though it's my language.' 'It felt like we knew what you were saying by the way you were saying it,' she said. I told her how sometimes I don't even realize what I say until after I've said it!"

"Maybe it's because I'm an elder now," Hazel comments. "I have so many grandchildren that I've lost count and I'm a great-grandmother, too. I always tell my children, 'Even though I've had sad times and happy times since the beginning of my life, it's been a good life. I didn't expect to be here this long, but I'm 80 years old. I lost my parents when I was young, but I thank the people who looked after me. That's why I'm here today.'"

"When we've gone to my daughter's and granddaughter's graduations they've called on me to give the opening prayer in our language," Hazel explains. "I've known the teacher for a long time and she didn't introduce me as Hazel, but called me by my Indian name. Now when I see people they don't call me Hazel anymore, they call me by my Indian name. I'm thankful for that."

"I don't really feel like I'm old," Hazel continues. "Sometimes I just feel heavy. That's when I don't like walking around town. Most of the elders tell me that I'm lucky I can walk, but my back aches when I walk long distances. The doctors say I've got a little arthritis in my spine, so I like to move around so I won't get stiff. My grandson made me a walking stick. He likes to look around for eagle feathers and finds them underneath old trees. While he was picking up feathers he found a limb that he made into a walking stick for me. I have never had to buy a cane. It has a piece of rubber on it so my hand won't slip. My other grandson carves, so he made me a walking stick with native raven designs on it for my birthday. He painted it, and it stays shiny the more I use. It's really nice, too."

"I remember an old man who came and lived in a house near my grandmother," Hazel recalls. "We used to walk over there and clean up for him. He used to live in Alaska and said he was a fortune-teller. One day he said to my granny, 'Sit down here and I'll read your hand.' He told her what he saw and then said to me, 'Can I look at your hand?' So I put both my hands out and he picked one. 'You almost died when you were young.' I thought of when I couldn't walk or get up. I just looked at him and said, 'Yes, I almost died when I was seven years old.' Then he told me I was going to have lots of kids and live to be a hundred. Well, I sure had lots of kids, but it sure makes me laugh when I think about living to a hundred!"

"I try not to worry about the diabetes," Hazel reveals. "I mostly worry about the food that I eat, but I'm happy the way I am. I don't think about it too much unless my blood sugar gets too high. Then I worry about myself, but my children are good to me. They help me forget and always like to put a birthday supper on for me. I say to them, 'I'm too old for that!' They say, 'No Mom, we love you! You stay with us.' So I just let them do it. They invite our friends and family and they all come. I feel close to all my children."

"When I think about the future, I hope to be here a little longer for my kids," Hazel explains. "That's what we were talking about when we first started, Sylvia, when my husband got really sick and how hard it was for the kids when he passed on. It's hard to lose the people we're close to. I've had to accept the diabetes. That's the way I am, but I also had to learn from different health people what to do. I think they should come to Bella Coola more often and gather everyone who is living with diabetes together. And I think we have to learn from each another what to do. Sometimes it's hard for us to believe what the doctors and nurses are trying to tell us, but we should follow what they say. I say to myself when I feel sad, 'Why should I be sad? It's a nice world out there and I should quit feeling sorry for myself. I should forget this sadness.' Sometimes I think about my ancestors and get emotional, so I say to myself, 'Why should I feel this way? I should enjoy my life and all the good people in it!"

I gave Hazel a hug and helped her down the front stairs of the house. As she stood before me and smiled, transferred to a still frame of my camera was her image gracefully etched and personified. I could not help but think of all the relationships she had experienced in her life, and how she was continuing to influence the wellbeing of others. And I could not help but consider the death of children – there is so much loss in all the narratives. Fortunately, Hazel was a pillar of support and security to her family and people in the community. And in her own way she had become an elder whose mature being shone with the worthiness of personified integrity and deep respect.

In what follows, I examine honoring the diabetic self, revealing the diabetic self to others, a diabetic sense of community, and walking in both worlds with the health people by way of Hazel's narratives, which shed new light on interpreting relationship within aboriginal reflections of living with diabetes.

Honoring the Diabetic Self

The relationship a diabetic person has with the self is a powerful and enduring connection. It is instrumental in shaping a life. And it is a connection without meaning in the absence of human values and thoughtfulness. As an aboriginal diabetic woman and keeper of her people's first language and culture, Hazel is not only a source of inspiration but also a link to what can be admired and respected in a world of diabetes. For in Hazel's memories of a difficult life and uniquely loving one, she related with a boundless heart that which encompassed several generations. And with such long-sightedness of being viscerally connected to the past and the future, she entrusted herself to the relations of family, friends, teachers, and healers, as well as to other cultural keepers.

Evoking passion within me, Hazel spoke of her compelling and moving life stories in a way that included the matriarch central to our lives. She was a grandmother and emerged from our conversations a symbol of strength - *a knitter of life*. It was an existence built on touching and tragic narratives entwined with hard work, love, and reverence. I perceived in that medium handcrafted ways that reflected how she influenced others through cultural thought and spirit. For Hazel exhibited an attitude of deep respect combined with affection in the telling of her stories. And they were cross-cultural narratives that were always changing.

As the content of those stories shifted and caught her attention, she told with simplicity the brittle reflections of living with diabetes. It was through those reflections that I perceived in the interpretation of relationship reverence for the human spirit and a diabetic way of living, reverence for courage to value one's own diabetic experience, and reverence for daily diabetic rhythms supported by family life. And there, too, existed reverence for the elders and their traditional ways, as well as reverence for the generosity that reveals itself through reciprocated connections with others.

Following our conversations, I imagined how Hazel remained with her thoughts - *stayed with the sighting of the bear* - to reflect on what diabetes was teaching her. Her mind used past symbols and interpretations to notice the significance of the present in order to create relationships in her life for the future. As I gazed into an aboriginal world-view and contemplated Hazel's perspective, I appreciated the use of circle concepts and traditional moral teachings. They were ancient ways of problem-solving being passed down from the elders into the day-to-day fragments of aboriginal lives. In exhibiting reverence for the human spirit and a diabetic way of living, Hazel was in the midst of relationship between herself, her family, and the ways of traditional elders that was dynamic and always changing. For in those relationships characterized by intuitive, relational, experiential, and cognitive interactions was a framework of aboriginal cultural origin. And Hazel was a viable part of that origin, remembering how early childhood options of music, dancing, storytelling, and language could provide clues to the kinds of choices needed to support the development of lifelong wellbeing for aboriginal people and their community.

From a point of view of the human spirit as being able to guide a diabetic way of living, Hazel and I explored the complex idea of who she had become. It was a process of opening herself up to the role and function of the elders, traditional healers, ceremonial keepers, medicine people, and users of native language as manifestations of native knowledge. For it was a contribution that Hazel perceived as a core strength, and one in which she shared and gave the world. And in the revitalization of language within her community came a process of re-energizing a belief in ancestry, culture, tradition, and local custom. Hazel knew how her language had been developed and found within it the ability to understand the world more fully. It was a world made more complete with linguistic uses of metaphor, which had a cultural way of taking Hazel from what she knew to what she realized she did not know.

As Hazel worked in the community in her role as moral teacher, the use of language also fostered a cultural perspective that enabled her to view alternate ways into humanity. It is a cultural place where the development of mind, intellect, senses, and intuition blossoms. Such an integration of ideas affected her experience of living with diabetes, as well as her sense of self honor. For in those experiences came further considerations of diabetes and concerns about culture, tradition, and social change. And Hazel was aware that these realities affected all indigenous people everywhere.

The stories Hazel told revealed in every aspect of living with diabetes the *ideal*, which she described, but they also revealed what was *real*, which was how she actually experienced life. I believe Hazel risked telling her stories because of the strong notion she had of herself, as well as the cultural human condition that made up her diabetes existence. For in those stories are reflections not only of Hazel's deliberate acts of honoring the diabetic self and its interpretation of relationship, but also the awareness of its relevance to young people living in the community, whose identities require shaping by cultural orientations and values of Nuxalk ancestry.

As I situated Hazel's stories in an experience of research, I realized how her narratives had become known to her as *honoring stories* – and how she realized that within the context of a changing culture, agency associated with a diabetic way of living was worthy of inquiry, too. Such an examination inevitably led to the preservation of the human spirit. And so I began to appreciate more deeply how aboriginal people traditionally used storytelling as a teaching methodology, how particular stories were used to teach about culture, history, environment, and moral practice, and how stories were always used to entertain. For in many of Hazel's stories I was privileged to listen to a set of moral teachings that Hazel was sharing with her people, narratives on how to be a better human being.

The courage to value one's own diabetic experience re-energized Hazel's ability to view herself as a person, a member of the Nuxalk Nation, and a contributing member of a native community. As she discovered this courage, it was associated with regaining culture, responding to change, knowing diabetes, supporting kinship, and revitalizing Nuxalk beliefs. It was also associated with a realization that spiritual beliefs are crucial to embracing the work necessary for living with diabetes. For change of a genuine and reliable nature is based on understanding the human spirit and a diabetic way of living from different angles. And Hazel's responses to those angles have been as varied as the seasons themselves - *the spring, summer, fall, and winter of her existence.*

Hazel shared stories of Nuxalk identity and living in a bicultural word. In them were reflections of living with diabetes that revealed knowledge of the aboriginal person she had become. She had grown respectful of learning to live with diabetes amidst cultural roots, the Native community, and society at large. They were places where her identity evolved and grew strong. For Hazel enjoyed talking about what it was she continued to understand as a human being. And her stories revealed sharing her life with other people, embracing an evolving diabetic identity, and relating to the ancestral philosophies and traditions that stimulate deliberative and reflective thoughts.

Hazel focused on the daily diabetic rhythms and the support of family life as a way of honoring the diabetic self. Her receptivity to learn from diabetes and satisfaction with its management had to do with her frame of mind and value of family ways. It led us to the ideas of compassion, respect, and truth as Hazel understood them, which she described in terms of always making room for others to come into a circle of learning and sharing. Her life had taught her that these were important acts that she and her family were required to live by. In experiencing diabetes and the work it necessitated behind the scenes, I viewed Hazel as living in a *circle of courage*, a philosophy whereby she considers all diabetics are alike regardless of the ethnic community from which they come. It is a view from where she honors relational support as an integral component in the process of learning to live well with diabetes.

During our conversations, Hazel reinforced the importance of involving elders who could pass on traditional knowledge, especially traditional healing knowledge. And who did so without reluctance as part of their teachings, especially with young people. She believed that special connections to the healing spirit - *to the honored diabetic self* - helped to strengthen cultural identities, as well as diabetic ones. Hazel and I recognized in the healing spirit a reverent power associated with diabetes that results in a particular wellness experience through healing acts of a physical, emotional, spiritual, and mental nature. For Hazel had learned to appreciate how her diabetic stories had engaged her as a responder in ways that helped her to think deeply and reflect widely on past and present reactions, as well as chosen actions. And they were visible acts that wove their way as much through her experiential stories as they did her diabetes stories. Such reflections reminded me of Archibald's (2001) reference to this form of pedagogy as *story work*, whereby 'the engagement of story, storyteller, and listener create[s] a synergy for making meaning through the story and making one *work* to obtain meaning and understanding" (p. 1).

Profoundly, honoring the diabetic self is about reflecting upon the whole self. Hazel placed great importance on language, because it is a way of transferring Nuxalk culture, ancestry, and history to the younger generation. It connects her to the past, elicits her consideration of relationships in the present, and establishes her role as an elder for the benefit of the future. And in doing so she has become an honored one. Thus, Hazel assisted me to appreciate, further, the cultural importance of language and the instrumental ways elders keep viable and strong, a collective cultural identity.

Hazel possesses a cultural identity entwined with a diabetic one. It is a coalesced identity that thrives on viewing diabetes from a stance of healing. From that stance, she shares the experience of living with diabetes, as well as the experience of living a cultural identity, through storytelling, cultural history, Nuxalk tradition, and life principles. And in speaking so, Hazel honors the diabetic self and honors the cultural self as if they were one and the same. It is a perspective that utilizes a multitude of connections to nurture the art of passing on valuable teachings in the process of honoring others. As Hazel and I conversed, my eyes gazed on an amenable self. It was a person derived from experiences that were enhanced and made insightful through acts of reflection and speaking. And from those acts spun with wool derived from the reverence of ancestral teachings were understandings of living with diabetes, knit by hands whose fingers stretched from an honored, aboriginal, diabetic being.

Revealing the Diabetic Self to Others

Hazel's persona expanded outward to family, friends, relatives, and people in her community and beyond, as well as to animals, growing plants, mother earth, and the universe. In particular, I came away from our conversations with a deep awareness of her concern for children and youth in the community. For in Hazel's narratives were reflections of her perceptions and prayers expressed to enhance the lives of others, which extended from a spiritual center that celebrated a wider community. And in that wider community she recognized how identities are always reforming through established social connections, which make opportunities for personal achievement meaningful.

Hazel was always trying to help herself so that the diabetes would go right. She knew how its lessons could reverberate through to family and community. And she viewed them as lessons needing to be spoken, because they were born from memories derived from the knowledge of a diabetic life. As a respected community teacher and mentor, Hazel was called upon to give away gifts of a spiritual and healing nature. She gave the opening address at gatherings with deeply felt prayers and words of compassion. And in doing so she instilled a reverence for life that was expressed in words, as well as actions, of the love she had for her people and their native cultural ways. Thus, she was sought by many to deliver the spiritual guidance and support that was requested as if from a large and extended family. And she did so willingly, with many people calling her Mom, because she was deserving of the respect that had developed in the relationships she had touched.

During her elder years, Hazel took on the responsibility of teaching by example through interactions with others, attending ceremonies and cultural events, giving public talks, and participating in celebrated community events. As her diabetic life became embedded in a rich aboriginal life, she taught about respect, responsibility, and reciprocity in multiple ways. And as she taught by example, those around her were exposed to the reasoning, repetition, and relations that are needed in order to know and live a diabetic life better – ways of diabetic knowing.

Hazel's sense of social connection was an important aspect of her daily experience. It helped her to survive and thrive. By revealing the diabetic self to others, she openly expressed from her heart and spirit a way to live, which included an inner vision of what it meant to be well. For her stories of living with diabetes included the energy that awakened her being to the creation of a new life. And it was a diabetic life linked to the pulse of her people and what they emotionally felt. Such an expression of creativity to redefine oneself as a diabetic assisted Hazel to live a prosperous diabetic life. It was a view of life that guided her destiny, hopes, and dreams. And it reminded me of our innate human capacity to renew our perspective on the world when it requires renewing. As the words of Cardinal (1996) reveal:

> There [are] only tremendous possibilities if you're willing to stand out there and leap off the edge. Because that's where true creativity exists; that's what we have to do to create a new life not only for ourselves, our children, our grandchildren, but to make a contribution to other people living in a small little world. (p. 15)

There also existed in Hazel's experience of living with diabetes creative impulses. She recognized them during years of experiencing a bodily condition that caused its share of turmoil, as well as a creative desire that led to a place of wellbeing. Instead of a pervasive view of diabetes becoming a negative life force, Hazel associated her mind with a vision of diabetes as life enriching. Thus, her experiences of diabetes became life sustaining. And it propelled her forth with the movement, sound, and sight of the beauty that exists in the world and its interconnectedness with all things.

Hazel spoke of her experiences as a story told inside a story. It is through the inner story that oral traditions are kept viable, being passed down from generation to generation and kept alive in our memories. As I listened to Hazel's inner stories, I became aware of how she revealed her diabetic self to others in ways that embodied practicality and usefulness as important ideas to learn by. And those ways offered guidance in living with diabetes to those who wanted to relate to her diabetic thoughts and reflect on its practical relevance in their lives. For as Couture (2000) writes of aboriginal epistemology, "ages-old understanding is comprehensive and leads to the development of mind, attitude, and adaptation in conduct" (p. 161). I perceived in Hazel an appreciation of how to listen to the important thoughts of others and then to speak with others, because they determine the direction and duration of thoughtful and knowledgeable human exchange.

I also perceived in Hazel the ability to provide others with the time and encouragement to hold onto their feelings in relation to different cultural viewpoints, as well as onto the array of diabetic sensibilities that they may have experienced. She had the capacity to tell stories from an affective, as well as cognitive, angle. In revealing her diabetic self to others, Hazel also offered what she knew based on what had been in development her entire life. Encouraged by her adoptive parents and grandparents, it was a life accustomed to sharing one's thoughts and feelings, because the development of a human being requires us to experience our reflections in the eyes of others. It was this wisdom that I perceived Hazel to possess, which made her, in part, an authentic and effective elder, as well as a *diabetic knowledge keeper*.

A Diabetic Sense of Community

Building diabetic relationships extends beyond health clinics to people living with diabetes and the community, where people experiencing diabetes seek each other's support for learning and sharing. Hazel had her own way of getting family and friends involved. And in her stories were illustrations of how she attended to aspects of cultural wellbeing. In a holistic way, Hazel incorporated culture and language, as well as Nuxalk and community norms and values into her teachings and conversations with others. She did so in a way that reflected equitably balanced relationships that dealt with thoughts and emotions associated with history and colonization. For Hazel's stories spoke of the interrelationships and connections of people to each other and to an aboriginal past, as well as to the diabetic realities such a phenomenon presents. They are stories reflective of an ongoing inquiry into how people living with diabetes, as well as associated health people, can overcome ineffective practices that exist. As Hazel reiterates, sitting together in a circle with a community, family, and people living with diabetes helps us to engage in responsible self-direction, healing, and wellbeing.

Hazel's narratives also assisted me to consider a diabetic sense of community in relation to the different contexts of people, township, and the larger society. A diabetic sense of community needs to direct not only the advancement of diabetic prevention and intervention in the lives of aboriginal people, but also in the practices of health people. It is a tangible sense of what is required being spoken by people living with diabetes using a holistic framework, and influenced by youth, citizens, and elders representative of the community fabric itself. Hazel assisted me to recognize that the primary focus of community diabetes awareness needs to be in the teaching-learning-sharing relationships between diabetics, health people, and community members. It is a focus based on a relational philosophy, whereby each person living with diabetes is part of a family and a community – *a location with a diabetic past.*

Hazel's diabetic and life stories gave voice to the significance for families and the community to establish and perpetuate ways to connect in order to affirm, value, and include the language, as well as the cultural practices and knowledge people possess, in a meaningful way. Such partnerships hold possibilities of establishing new ways to motivate, vitalize, and reenergize diabetes prevention and intervention programs that result in pervasive life-sustaining healing practices. And foundational to a diabetic sense of community is its present realities that influence people's discovery and capacity to nurture their health and wellbeing. For everyone has a responsibility to participate in the work of alleviating and deterring the effects of diabetes, because efficacious diabetic practices occur as a result of authentic and desirable relationships between diabetics, families, elders, health people, and the community. Thus, Hazel was able to share with me how she was situated in, and affected by, the complex historical context of culture and ancestry that went along with the integration of diabetic life threads.

A diabetic sense of community also reflects a way of life. Hazel recognized the need for a diabetes initiative to improve the quality of life for her people. And she recognized the need to explore and build connections between diabetics, healers, community developers, and those with a desire to discover their own healing path. For as Gaikezheyongai (2000) suggests:

> Stepping onto the healing path … entails developing the willingness to explore one's social reality and accepting self / identity to assert one's rightful place and purpose in a society that still aims to assimilate First Nations people. (p. 11)

Such a contention was reflected in Hazel's personal resources, and from where a shifting of her collective mind, heart, and spirit awakened, had room to expand, and assisted her to seek a vision of wellbeing for others. For Hazel's approach to her own diabetes journey was the kind of activity that fuels the emergence of a diabetic sense of community. And it was a location that placed importance on reclaiming traditional knowledge supported by the wholeness of self, which in turn supported a more balanced approach toward living with diabetes. Thus, it became clearer to envision a diabetic sense of community that presented a contemporary approach to diabetes for aboriginal people that was holistic, culture-specific, and community-based. And one by which to reflect a worldview and in it the values and practices of social interaction that are not only culturally sensitive and appropriate, but respectful.

Hazel was proud of what she was, and I marveled at how she honored the diabetic self. She continued to acquire the diabetic practices that were assisting her to learn and experience the wellbeing that can be found in a diabetic life. And she saw in those experiences the necessity for a diabetic sense of community which was similar to a cultural sense of community, assisting her to recognize, desire, and nurture, further, an aboriginal sense of who she had become.

Walking in Both Worlds with the Health People

As a person who understands the relationship between aboriginal community members and school communities, Hazel's participation as a classroom language teacher made positive connections that supported aboriginal children, youth, and families within the community school. She recognized that these relationships could be used as a tool to promote a better understanding of the aboriginal perspective, which influences all aspects of living an aboriginal life. I perceived in these relational stories and Hazel's reflections of them, respectful ways that brought aboriginal contexts and relationships together. It is a process based on furthering partnership work and on questioning the multitude of methods, approaches, and practices that exist.

It was in such context-specific dialogue with Hazel that I considered the need for a supportive aboriginal diabetes context, places that provide useful ways of developing practical understandings among aboriginal peoples and health people on various questions, including those focused on experiential and cultural exchanges related to diabetes knowledge. Our conversations also served to highlight for us the salient features of honor and respect within aboriginal ways of knowing and being. And Hazel assisted me to understand what this meant. For it was the need for people to be part of specific declared motives and methods that relate to the creation of joint diabetes opportunities, as well as to solutions for addressing equity issues inherent in them. All of which are recognized and culminate in acts of teaching, learning, and sharing – *the perpetuation of respectful diabetic spaces of doing.*

In terms of walking in both worlds with the health people, Hazel also recognized the extent of her interdependence with them. In a cultural context of participation and reflection, she brought to such interactions a consensual social approach that was fully consistent with aboriginal principles. And as an elder, she brought an atmosphere of reflexivity and personal reaction to the diabetes encounters, as she examined diabetes from a cultural perspective. For Hazel had discovered that such basic components of conversation and dialogue prove useful and adaptable when met with cultural differences and expectations between aboriginal people and non-aboriginal health people. And she was eager to *walk* with these *health people*, just as she was eager to acquaint herself with the ways of wellbeing *in both worlds*, when faced with diabetes.

The quality of Hazel's health *people* stories were related to what she had learned about diabetic healing, an increased honoring of the self, and the strength of her aboriginal identity. As a person living with diabetes, the telling of those stories had given her the confidence to meet the challenges of diabetes in her life. For over the years she had managed, effectively, that challenge. And she had brought about a way of diabetic healing that was a re-visitation of what she desired, intensely, in order to sustain the viability of a supported diabetic life. Such diabetic reflections had taught her how to be patient and flexible in her ways, just as the world of ancestors and the world of traditions suggested. In keeping with the aboriginal principle of honoring the person and perceiving their point of view as something of value, something to be respected, Hazel was receptive to the advice of health people, but did not always adhere to their suggestions. And I believe that this was due to the culture-specific aspects in their discussions of diabetes remaining, to a large extent, invisible and relationally unexplored – lost meaningful opportunities for learning and sharing.

As I thought, deeply, about the lived relations transpiring between Hazel and her health people, I considered the longing in her heart to reach out and grasp that which she still requires for survival – the continuance of self-managed and self-directed practices related to diabetes care. For walking in both worlds with health people meant trying to achieve the best possible results in the day-to-day work of personal healing and wellbeing. Such vigilance involves recognizing, watching, and adjusting by health people and herself, the responses arising from a complex diabetic life.

As Hazel assisted me to view the importance of relationship between the diabetic and health person from multiple angles, its importance became even more visible in terms of influencing Hazel to achieve continued success. Although honoring the diabetic self, sharing the diabetic self with others, and contributing to a diabetic sense of community all support Hazel's wellbeing, walking in both worlds with health people is particularly important. For certain relational qualities and characteristics experienced by both Hazel and the health people together become essential to the creation of respectful diabetic spaces. They are places within an evolving relationship where threads of respect continue to form authentic personal connections, which have a way of keeping such tenuous relations alive. And it made me wonder about the extent to which health people actually focus on the significance of relational elements, such as creating a cultural climate of trust, listening, developing a relationship over time, or recognizing the experiential aboriginal knowledge that Hazel living with diabetes brings to the exchange.

As a narrative inquirer, such intricacies led me to consider the crucial necessity of establishing meaningful exchanges - the potential to pass on *real* parts of each other that have a chance to contribute to a storied exchange as an element of a diabetic's and health practitioner's ongoing relationship. And it is the storied form of validated experiences that assists Hazel to share, comfortably and easily, that which is not only an exchange of self explanation but an enfolding process of diabetic knowing. For it is a way of being with health people that is social and friendly, based on a premise of dialogue that elicits the telling of a full range of human experiences. Such interlocking narratives about life and diabetes are essential to understanding the healing and diabetic practices hidden in aboriginal stories of diabetes.

Hazel shared with me, through her narratives, strong and powerful relational threads that were providing her with deep and lasting affective bonds. Recent or in memory, they were aspects of her existence that influenced not just a diabetic life, but a past and foreseeable one. For it is through our sharing of a few authentic relational encounters focused on the mundane day-to-day activities of our lives that we invite entry from others into the details of our lives. And in those details lies the knowing that such possibilities in the form of a mutually beneficial relationship between diabetics and health people may exist and be realized. It is the creation of a shared belief of the world of diabetes that constitutes beneficial action - *walking in life together* - which arrives, unknowingly, at acquiring specific knowledge so desperately needed by human beings. Significantly, such a reality constitutes even further action – *walking in both worlds* - which assists, almost effortlessly, in making the demonstration of effective diabetes practices reflective of a cultural perspective, obtainable.

In terms of diabetes education, it is imperative that aboriginal people who live with diabetes relate to health people in ways that perpetuate the sharing of genuine threads of social connection. By doing so they have an opportunity to direct a vision through the creation of a learning pathway that is holistic and motivating in nature. The words of Cajete (1994) remind me of the possibility of such partnership work:

> …in every learning process, we metaphorically travel an internal and many times external landscape. In traveling a pathway, we make stops, encounter and overcome obstacles, recognize and interpret signs, seek answers, and follow the tracks of those entities that have something to teach us. We create ourselves anew. (p. 55)

For in lived aboriginal and non-aboriginal diabetes experiences, it is the memories of successes and challenges that comprise the internal and external landscapes people travel. Within the internal realm, I thought of Hazel's diabetic experiences, self-knowledge, and personal inner world as being significant aspects of her relationships with the health people. It is a world, too, where the health people grappled with complex internal aspects of their own. Within the external realm, I thought of the array of diabetes services and resources that they both require in order to work towards an equitable partnership of wellbeing. Such a location of internal and external realms, if done successfully, epitomizes walking in both worlds – *the capacity to engage in overlapping cultural realities.*

Hazel's stories reflected continuing educational sessions, affirming relationships, and sharing of experiences associated with the world of diabetes. At times it was enough, but at other moments I had a sense that something was severely lacking. I surmise that Hazel was supported as a person by the health people, but not necessarily as an aboriginal person. As health practitioners, we do not just convey acceptance, create a climate of trust, and listen in terms of relationship building with a particular person. We do so along with our perceptions and experiences within an entangled paradigm of culture, be it native, aboriginal, or indigenous. And as I considered the health people's ability to focus on aboriginal people's strength and resilience, I thought about how they need to reaffirm aboriginal people's confidence, be flexibly accessible toward them, and place value on the development of a cultural relationship over time with them.

Hazel spoke of sharing knowledge within her stories. And I wondered if the health people who she had had encounters with were able to recognize the experiential knowledge residing within her, transfer information instead of just provide it, or feel what it is like to have been taught something of aboriginal significance. For I thought about how Hazel had facilitated her learning and personal development, as well as the development of others. Hazel's narratives are complete with helping people understand and name their problems, identify their potential, and honor their pace. She had discovered that taking small steps was useful, persisting in trying things out was beneficial, and modeling ways of approaching diabetic difficulties was gainful. And the intuitive sense Hazel exhibited through her public speaking had a way of focusing on strategic moments and key transitions of those who listened. Unsuspectingly, she provided for others opportunities to acquire knowledge – *the creation of enlightened spaces.*

As a result of our conversations, Hazel and I appreciated many new insights into the challenges of living with diabetes. We shared and validated the importance of helping each other build personal meaningful relationships, with a wider view of identifiable support sources, such as the complementary roles of family and community members, and programs that could provide specific diabetes assistance. The creation of an equitable environment for aboriginal people living with diabetes requires that one provides for emotional, mental, physical, and spiritual necessities. It is an environment that establishes many spaces of generosity, from which aboriginal stories of diabetes originate and are told by those learning, teaching, and sharing in the world of diabetes. And as participatory and equitable recognized places, they reach out to others in inviting ways.

CHAPTER EIGHT

Finding Harmony: Balancing Diabetes, Culture, and Wellness

Spirit Winds: A Narrative Inquiry into the Aboriginal Stories of Diabetes was a research project that came to fruition in response to an epidemic in progress within aboriginal communities across Canada. Its purpose was to understand an aboriginal person's experience of living with diabetes. Narrative inquiry (Clandinin & Connelly, 2000) was the methodology that guided the research and dialogue and conversation were used to retrieve a storied view of experience. The study highlighted three years of co-participation with one man and three women of aboriginal ancestry, a journey that elicited their rich life narratives and revealed meaning in their particular diabetes stories. It involved five years of scholarly and personal explorations in acts of listening, learning, sharing, and writing by the author in order to understand a cultural view of experience. Ultimately, the co-construction of a narrative about diabetes, revealed as a process of healing and wellbeing within a context of being aboriginal, was explicated.

As previously described in the methods chapter, three sets of narrative inquiry considerations for understanding experience were used to direct the analysis of the study: theoretical considerations; practical, field text-oriented considerations; and interpretive-analytic considerations. Guided by these topics based on hermeneutic phenomenological philosophy, I present in this last chapter an interpretive-analytic synthesis and discussion based on the preceding four findings chapters. My intention is to elucidate, further, the personal and human elements, as well as the cultural and healing dimensions, which surfaced through narrative and an interpretive dialogue with the text.

It is noteworthy to mention that the inquiry was undertaken against a background of little qualitative work on the aboriginal experience of living with diabetes, and none that explored it from a cultural perspective based on the existential dimensions of time, place, body, and relationship. It is my view that this research will make a contribution to the knowledge base in the area of aboriginal diabetes health by revealing four extraordinary people's experiences related to finding harmony and balancing being aboriginal, being diabetic, and being well. Clearly, the study does not predict or generalize, but rather provides an in-depth understanding of what their diabetic issues and concerns are, which helps to anticipate their future events, as well as assists to develop understanding of the significance that diabetes events and topics have for aboriginal people, their families, and their communities. It also has the potential to stimulate further inquiry into the experience of living with diabetes that involves other aboriginal peoples whose land is part of Canada, as well as indigenous peoples whose lands are part of countries such as Australia, New Zealand, and Alaska. It is in Australia, for example, that a major recent review has revealed that some of the highest rates of aboriginal diabetes in that country are found in Central Australia and the Torres Strait Islands (de Courten et al., 1998).

This final chapter is organized into nine sections. It begins with three overarching analytical interpretations that emerged from the inquiry and is based on the participants' lived experiences. These interpretations are followed by a consideration of the cross-cultural, professional, and personal contributions that arise from them, which relate to the enhancement of practice and research by healthcare providers. In the seventh section, an emphasis on the theoretical contributions of the inquiry linked to colonial theories focuses on the complexities of sociocultural realities in relation to my own understanding of the aboriginal experience of diabetes. The eighth section focuses on how my findings inform nursing practice, education, and research, the ninth section on my reflections of future nursing development.

Cultural Differentiation and the Diabetes Experience

I begin with the first overarching interpretation that questions the way in which aboriginal people living with diabetes experience the world. It was from such questioning that a desire to want to know a cultural world, in which aboriginal people experiencing diabetes live as human beings, was satisfied. *Aboriginal experiences of living with diabetes are profoundly different from non-aboriginal experiences as we think we know them.* First, in a time of rapid global change and increasing social, political, and cultural complexity, the need for understanding aboriginal diabetes as a progressing epidemic is expansive and perplexing. There is urgency among public, voluntary, and health sector organizations to understand the ever-evolving phenomenon of diabetes as aboriginal people experience it, to develop strategies from the stories that are being constructed about themselves as diabetic people, and to be able to respond to the challenges that shape who they are while living with diabetes as a process of healing and wellbeing.

Second, as explicated through the four findings chapters, an awareness of the profound cultural differences, unlike the way we think we know them, arose from understanding an aboriginal diabetic self through George's stories, inquiring into the aboriginal experiences of diabetes through Emilie's stories, recognizing diabetes as a gateway to aboriginal healing through Violet's stories, and interpreting aboriginal reflections of living with diabetes through Hazel's stories. They are narratives in which each participant speaks of language and spirituality, family and social networks, elders, cultural and communication patterns, diabetes issues and concerns, diabetes care, illness and bereavement practices, as well as traditional healing options. And they are narratives from which in-depth insights into their cultural orientations, into diabetes as a process of healing and wellbeing, and into underlying belief frameworks revealed how profoundly different aboriginal experiences of diabetes are from non-aboriginal experiences of diabetes as we think we know them.

Third, I have discovered that most non-aboriginals are unfamiliar with aboriginal peoples' long, rich, and proud history of native ancestry and have had little interaction with them. Like most indigenous groups, globally, aboriginal peoples have, throughout their history, experienced ethnic destruction, broken treaties, forced displacement, wars, imported illnesses, legal discrimination, and human rights abuses. Today, although their health circumstances are improving, Aboriginal Canadians continue to experience some of the highest mortality and morbidity rates in the country of any ethnic group, and they have the shortest lifespan. The cultural orientations inherent in the notion of an aboriginal diabetic self are entwined with the understanding of an aboriginal identity. It is not possible to generalize when attempting to understand Aboriginal Canadians, because the cultural orientations of aboriginal people are unique to their particular tribal community, such as the Nuxalk Nation of Bella Coola, and are unique in their influences on the formation of particular diabetic identities. Part of finding harmony in balancing diabetes, culture, and wellness is recognizing that aboriginal people living with diabetes have a lot of stories to tell, and the value that is discovered in aboriginal stories of diabetes needs to be acknowledged in the same way that we recognize and demonstrate respect to life stories.

Fifth, in non-aboriginal cultures, learning is often separated from experience. In traditional aboriginal teaching, experience was always connected to learning. Inquiring into the aboriginal experiences of diabetes is about understanding the holistic experience of living with diabetes. This means beginning with an aboriginal person who is living with diabetes and experiencing healing and wellness, not just weakness and sickness. George, Emilie, Violet, and Hazel teach us about what a diabetic person experiencing wellness is all about, because by starting there, they understand that the strength and the resources within other aboriginal people experiencing diabetes will be seen first. They recognize the need to shift away from creating first impressions of people living with diabetes as something about labeling people and about focusing on diabetes as pathology. Yet, the more a person attempts to explain diabetes, the more one removes it from its context.

In sharing their aboriginal stories of diabetes, the participants did not try to define an experience of diabetes, but rather always located it within a context of living and values. Diabetes is then recognized as a living thing, just as aboriginal culture needs to be recognized as a living thing. When inquiring into the aboriginal experiences of diabetes as a living thing, it becomes a complex thing, because it will vary. The aboriginal stories of diabetes that the participants tell may not change, but those who listen to them will change. For those who hear the stories over and over again across time, and who acquire different experiences, they will understand what those diabetes stories are about in ways that influence them.

In terms of context, language and spirituality are critical factors. The participants spoke English as their primary language and cultural differentiation was revealed through various aboriginal phrases and words that were often worked into everyday speech. Some of the participants still knew their native language, but spoke of how they experienced interruptions in speaking the language of their ancestors, and how they relearned it and passed it on through special cultural classes held in the school that was located in their community. From a spiritual perspective, the participants mixed some form of Christianity or another religion with native spirituality, which they spoke of being practiced in ways that guided their approach to life, as well as a diabetic life, in a sacred and holistic manner.

In relation to family and social structure as context, the participants placed great emphasis on children, family, and the extended family. Participants revealed how the notion of family formed the basis of their aboriginal society. Depending upon a particular social experience or situation, participants also spoke of their culture as placing great emphasis on individuality, equality, and the important role that each person plays in contributing to the family, the group, the community, and the society at large. They all placed great value on the elders and on the practical knowledge that they possessed, including diabetes experiential knowledge. They spoke of how they taught younger people always to treat elders with genuine and sincere respect, and to be responsible for bringing honor to one's family, tribe, ancestors, and community.

The participants revered their elders and ancestors for their wisdom, knowledge, and advice. They spoke of the tensions that now existed in some families as a result of acculturation, poverty, and the breakdown of traditional native society, but also of the acts that revere the elderly, which continue. By telling their aboriginal stories of diabetes, they try to see through different kinds of eyes and move away from one way of responding – of one pattern of diabetes practices – to many. As elders, the participants played important roles in decisions that affected the wellbeing of the family, particularly in terms of the genuine love extended to children and grandchildren. In terms of inquiring into the experiences of diabetes, they fulfilled significant roles in decisions that affected the healing and wellbeing of family and community members who were living with diabetes and looking within it, a healing and wellness process.

Sixth, part of the aboriginal healing and wellness process of diabetes is realizing there are many ways of perceiving and understanding the world. The participants did not just tell one story, they told many stories in order to share as many perspectives as possible, because that is what finding harmony is about. Harmony exists only as a result of difference, because everyone will not experience diabetes in the same ways. This diversity is inherent in finding harmony and balancing diabetes, culture, and wellness. Recognizing diabetes as a gateway to aboriginal healing, the participants considered this diversity as something to be celebrated. I listened to the ways in which they told their stories – their cultural styles of communicating – that were expressed reservedly, thoughtfully, and subtly in direct expressions of feelings and emotions. Their voices were always calm, quiet, and polite, characterizing our conversations with long pauses, silent reflections, metaphors, and more stories.

From a healing and wellness perspective, the participants revealed narratives that reflected both difficulty and ease with accessing diabetes care in their community. Transportation and geographic barriers posed by living in Bella Coola also were significant, particularly if there was harsh weather or if there were medical providers who were new. This was part of their healing perspective, and a way of recapturing one's wholeness. In addition to a part of finding that wholeness were stories of how the participants valued their traditional healing practices mixed with stories that revealed feelings of both comfort and discomfort when seeking care from health professionals located in a clinic or hospital. Within those contexts, they spoke of family and community members as having experienced many conditions besides diabetes, such as obesity, alcohol misuse, and accidents that resulted in severe, disabling injuries, as well as death.

Seventh, diabetes as a gateway to aboriginal healing and wellbeing is about the reclamation of wholeness. It is about forming a diabetic identity, retaining a language, reclaiming spirituality, and whatever it is that makes a difference. It is about a healing and wellness process in the sense of reclaiming wholeness of mind, body, and soul. And it is about reclaiming wholeness of the universe, perceiving balance and imbalance within it, because as human beings, we are mirror reflections of its wellness. That is the healing process that continues; it is not only working on food choices within perceptions of a modern diet that consist largely of starchy foods, refined carbohydrates, and high-fat products, but also those intentional steps taken to heal Mother Earth. Our consumption of her, just as with fresh fruit, vegetables, and traditional foods, has changed over time, due to a variety of complex factors. On a grandiose scale it relates to our need for a higher standard of living, and on a small, practical scale it relates to aboriginal peoples' limited incomes, availability of consumer goods, and acculturation. Another influential factor, however, was the change to the participants' diets that related to living with diabetes and eating certain amounts of particular foods that make a diabetic person heal and feel well. These changing conditions were expressed along with physical symptoms such as aches, pains, and fatigue. They were also combined with emotional despondency that was perceived as being caused by a person's disharmony with the environment, the spiritual world, and with personal relationships. Participants revealed in those stories how mental imbalances could be considered the result of violations of cultural prohibitions, negative energy, and evil spirits. They were stories that touched on how spiritual practices and traditional ceremonies brought back the pursuit of finding harmony, which was a balance that needed to be discovered between being diabetic, being aboriginal, and being well.

The participants recognized a variety of treatments for diabetes, which was a condition that they viewed as having been introduced to indigenous cultures by outsiders; they considered mainstream medical care to be the most appropriate for treatment. Their stories revealed how the diabetes condition was, at times, concomitantly treated with traditional medicinal, spiritual, and ceremonial purification practices as well. And their stories revealed aboriginal experiences of alcohol misuse, which were considered to be a severe reaction to a person's imbalance in relation to the self, others, and the world. These were stories that revealed experiences of alcohol misuse, which were connected to experiences with loss of culture, identity, and aboriginal soul.

Lastly, interpreting aboriginal reflections of living with diabetes had to do with interpreting a sacred phenomenon, because the participants always spoke of reclaiming wholeness as sacred work. From a combination of interconnected narratives, I listened to bereavement stories and how family members and friends had visited an ill or deceased person. Depending upon how traditional the people in their stories were, those visited would receive a variety of healing ceremonies that were often communally performed. The participants told within their stories of how the spirits of the dead in their culture are honored regularly for generations, and how death may be considered to be merely the beginning of another journey into the next world. It was then that I appreciated more deeply how in terms of traditional health options, the participants spoke of their use of plants and herbs along with a strong sense of connection to the earth and the universe, and with deep respect for all living and non-living things.

Interpreting aboriginal reflections of diabetes was also never far from interpreting more sacred work. It is from this location that the participants' stories about diabetes revealed a healing and wellness framework that was holistic, which combined physical, mental, emotional, and spiritual wellbeing. Physical problems were understood as usually being caused by emotional, mental, spiritual and physical imbalances. Harmony and a sense of balance in all things, including mind, body, spirit, and the environment, were consistently important for experiencing wellness. The participants assisted me to interpret their healing beliefs related to diabetes as more circular and indirect in comparison to the more linear cause and effect view of mainstream medicine. Thus, diabetes as a process of healing and wellbeing could not be separated from spirituality, and went beyond religion to emphasize the interconnectedness, sacredness, and balance of all things.

An Existential Understanding of Aboriginal Diabetes

The second overarching interpretation stems from a discovery in the world of diabetes of lived-experience material that, upon reflective inquiry, yielded something of its fundamental nature. *An existential understanding of diabetes in relation to time, place, body, and relationship creates a deeper connected sense with an aboriginal person's historical past, recent and present life.* First, in addition to the above supporting arguments, I am becoming slowly convinced that due to a demand for evidence-based practice, analysis, and understanding, organizations that would never have done so in the past – or would never have done so intensively – are now conducting social sciences and humanities research focused on experience. By having aboriginal people tell their stories of diabetes, knowledge generated is providing alternate interpretations of the tensions and conflicts that emerge from a world where consequences, values, politics, and moral dilemmas are abundant and central.

Second, based on an existential framework for understanding the meaning within aboriginal stories of diabetes, consideration of time in the first findings chapter not only revealed a dimension in which past, present, and future may be regarded as a continuous whole, but the concept further elucidated the ways in which a diabetic self is embedded within a person's own life narratives of experience. A sense of place in the second chapter not only revealed a dimension in which situation makes aboriginal people, the land, and the stories inseparable, but the concept further elucidated how aboriginal experiences of diabetes are embedded within a person's own narratives of experience. The inclusion of body in the third chapter not only revealed a dimension in which a physical or bodily presence is both visible and concealed to ourselves and others, but the concept further elucidated the ways in which diabetes as a gateway to healing is embedded within a person's own life narratives of experience. And the interpretation of relationship in the fourth chapter not only revealed a dimension in which human beings share significant interpersonal connections with others, but the construct further elucidated how aboriginal reflections of living with diabetes are embedded in a person's own life narratives of experience.

Third, it is my view that the likelihood of appreciating the details of such interconnectedness within cultural knowledge, which has implications for diabetes practice, research, and social health policy development, is far greater when presented through the existential notions of time, place, body, and relationship. An existential understanding of diabetes creates a deeper connected sense with an aboriginal person's historical past, recent and present life in terms of understanding the notion of an aboriginal self, inquiring into the aboriginal experiences of diabetes, recognizing diabetes as a gateway to aboriginal healing, and interpreting aboriginal reflections of living with diabetes. Such a framework also creates a connected sense that considers culture as only one of many factors that influence healing and wellbeing. Age, gender, income, literacy, educational background, lifestyle, amount of time in a particular location, personality, and so on become equally as important when attempting to gain a holistic understanding of the aboriginal experiences of diabetes.

Fourth, it is my understanding that such contemplation from multiple viewpoints will contribute to a platform of human understanding upon which social structure and human agency intersect. Indeed, Smith (1994) has so summarized the situation: "It may be precisely the inability of traditional [colonial] forms of discourse to deal single-handedly with the lived problems of modernity that makes interpretation or re-interpretation of contemporary paradigms and their institutional embodiments necessary" (p. 100 & 102). Further, acts of researching, questioning, and theorizing enrich how we arrive at knowing ourselves, our histories, our cultures, our successes and failures, all of which shape our being in the world with others. I have experienced through this inquiry a reciprocated witnessing of existence that reveals its own pedagogy of thinking and doing (theory and practice), originating from an approach that elicited the telling (research) of aboriginal stories of diabetes. By pedagogy I refer to the activity of teaching, treating, responding, educating, or generally being with aboriginal people living with diabetes, which requires constant practical acting in concrete situations of experience and relationship.

Lastly, an existential understanding of aboriginal diabetes underlines the importance of valuing an alternate culture of research through efforts that focus on the centrality of understanding relationship. The concept of relationality is key to increasing engagement and studying the underlying knowledge hidden within the aboriginal experience of living with diabetes. Thus, relationality led to the answering of other questions of meaning that arose from further interpretations, originating from a storied landscape of aboriginal diabetic knowing. It is a particular kind of knowing that makes me think of Smith's (1994) writing in terms of hermeneutic imagination and the pedagogic text. How might we orient our lives with aboriginal people who are experiencing diabetes when we can no longer take for granted what the aboriginal diabetic person is in any discrete sense? How might we orient our lives with them when we do not make problematic all of the usual categories for understanding the aboriginal experiences of diabetes in our mainstream culture (high blood glucose levels, behavioral noncompliance, obesity, et cetera)? And how might we orient our lives with them when we consider the question of meaning of an aboriginal diabetic identity as one which is not answerable except self-reflexively, that is from the question of who I am in relation to my practice and research? These are important questions that require serious consideration in order to answer them in ways that contemplate authentic relational action.

Authentic Acts of Mutual Respect and Caring

The third overarching interpretation originates from doing research that questioned the diabetic person's secrets and intimacies that are constitutive of the world of diabetes, and that brought such a world of research as a caring act into being for us (van Manen, 1997). *Mutual respect, as an aboriginal experience of being honored, may be understood as the ways in which a person thinks and behaves toward a person through acts of high regard that extend authentic caring to another person. And it may be experienced or expressed by each of two or more people about the other.* First, in addition to the above two interpretations and arguments, I am reminded of the words of Goethe (1963), "One learns to know only what one loves, and the deeper and fuller the knowledge is to be, the more powerful and vivid must be the love, indeed the passion" (p. 83). In other words, loving the people I know allows me to know the people I love. It makes me connect my own personal experience of how important becoming a new mother is to my deepened and fuller knowledge of relationality within family. From a new angle, I am discovering by being in relationship with my daughter what love is, why it has to be shared, and how my passion for her feeds me so genuinely. It is interesting how people tend to relate more lovingly to each other when children are present. We all have an enormous capacity for loving and my daughter reminds me every day how we must give that energy away to others. I am learning from my daughter a deeper sense of what people experience when they have wanted to know more people than they have, wanted to have loved them all, and wanted to have been loved by them in infinitely different ways. Family has become for me an island of light, amusement, and wisdom. It is a place where I run to with my discoveries, torments, and hopes at any time of day and feel welcomed.

Second, in the retelling of our professional relational experiences, there surface vital reflections of caring acts, love, and passion that may await recognition, of which something tenuous is acknowledged between the self, others, and the world. As a part of relationality within research, they are detailed, personal reflections that require sorting out in terms of what may be considered as contributing to authentic, culturally-relevant, and competent scholarship possibilities. We need to desire within research the kind of scholarship that encourages partnerships characterized by best cultural practices and that has the best chance of benefiting aboriginal people themselves. This depends on relationality, but there exist in the systems of healthcare and research new possibilities for dialogue and conversation. These are possibilities whereby people learn to develop a capacity to interpret material of their inner and outer worlds. In that capacity they learn to discover the strength that aboriginal people exhibit to overcome their specific diabetic challenges. It is in that strength that they learn to understand how responses to diabetes are often experienced, concomitantly, with the trials and tribulations of a host of other illnesses, adversities, and tragedies.

Third, these kinds of research partnerships that do not shy away from relationality with aboriginal participants, if on the right track, will raise questions related to the ownership of knowledge, as well as to the ethical questions and dilemmas that emerge from the experience of being in relationship with aboriginal peoples. It will also require continuous reflection on the concept of relationality. Wilson (2003) explains:

> The concept of relationality permeates recent scholarly writing by Indigenous scholars. They question whether in fact it is even possible for [colonial] system researchers to understand this concept with the depth that is required for respectful research with Indigenous peoples. (p. 173)

I think the whole issue of relationality is key to aboriginal diabetes research. It will determine what kind of relationship aboriginal people want with non-aboriginal, as well as aboriginal, researchers. And it will determine the abilities of aboriginal people to work with practitioners. We need to question whether in fact it is even possible for practitioners and educators to understand this concept with the depth that is required for respectful diabetes care and services with aboriginal people. It is in contemplating such answers that I believe my dissertation work informs and offers cultural guidance.

Fourth, as a person with nursing practice, education, and research experience, it is my belief that health professionals who conduct research are in an excellent position to contribute their relational expertise toward diabetes-related practice, education, and research in ways that promote culturally competent care. It will only be meaningful, however, if it incorporates aboriginal perspectives and theoretical explorations of culture, as well as its cultural differences and cultural specific knowledge about poverty, into the relationality and dialogue of such culturally competent work. And it will only be meaningful if it addresses the time required to establish, maintain, and sustain relationships within active and busy domains of life and work.

But as a result of enlightened leadership within research, pressing aboriginal health issues are being addressed, new approaches adopted, and new methodologies applied. At the same time, scholars who conceive of knowledge development as a social and communicative practice are in a position to close the gap that exists between theory and story. Much of what we do as social and cultural beings is to tell our stories. It is only with the personal expertise to negotiate a relationship based on authentic mutual respect, which is also reciprocal, shared, and constantly interchanging, that knowledge derived from understanding aboriginal experiences emerges.

Lastly, I discovered as a result of the relationality that existed within the narrative inquiry that the process was about interpreting the threads of life woven in the fabric of our daily lives. It was about eliciting from life stories the insight, essence, and resonance that accompanied our philosophical and cultural expressions, and our desire for them to be recognized. As a methodology congruent with aboriginal ontology and epistemology, the relationships formed were about witnessing a contemplative effort by aboriginal people to reclaim confidence in their identities, impart a political voice, and heal from colonial injustices. It was about developing a relationship with four participants in order to know a whole life. As a result, I believe that the participants were *at home* in this study, as was I.

Thus, the concept of relationality as part of our alternate culture of research recognized the whole, the unity or coherence of a life-story, in which the experience of living with diabetes as a process of healing and wellbeing was nested. Working with multiplicity, it was about new ways as researcher and participants that we engaged with each other. It was also about analyzing the existence of temporality, memory, and imagination that influenced both participants and the researcher, as well as our experiences of living the research process itself. I believe relational forms of inquiry will advance nursing development and practice beyond the boundaries established by methodologies that claim to know another culture on the basis of brief encounters. Thus, continuously reflecting on the concept of relationality within the inquiry provided me with ways of conducting research with George, Emilie, Violet, and Hazel, all of which speaks, narratively, to the ebb and flow of our overlapping lives, and to the creative new ways research by nurses can be developed and practiced.

Cross-cultural Contributions

In considering the cross-cultural contributions, I focus on what the inquiry has the potential to mean to aboriginal people living with diabetes, to their families, to their communities, and to the world. Reflections on aboriginal diabetic issues and concerns within a context of cultural differentiation, cultural complexity, and cultural interaction are included. Also evident in the cross-cultural section are notions of being diabetic, being aboriginal, and being well using an aboriginal framework of diabetic seasons. As ideas of transformation and transcendence, these conceptions use the interpreted voices of the participants to reveal the universal link between being well and being able to interpret experience and situation. As enacted themes within their diabetic stories, they represent favorable human conditions that provide the foundation for sounder social health policies. My intent is to reveal yet other ways the aboriginal diabetes experience may be positioned amid other streams of thought. As van Manen (1998) suggests, "...to *know* the world is profoundly to *be* in the world in a certain way, the act of researching – questioning – theorizing is the intentional act of attaching ourselves to the world, to become more fully part of it, or better, to *become* the world" (p. 5).

While diabetes, crisis, stress, illness, and aging are universal facts in all societies, each culture has developed different ways of defining wellbeing and making sense of physical, mental, emotional, and spiritual imbalances. Each culture has different ways for preventing or responding to disharmony within paths of healing, for managing physically altering events and phases, and for establishing roles and behaviors for both health professionals and recipients of diabetes care. The practices encompassing diabetic disharmony and wellbeing are not behaviors we possess at the point of diagnosis, but rather behaviors that are learned and shared through cultural processes over time, in a place, through a body, and by relationship.

The aboriginal perception of time considers the arrow of time – the past, present, and future regarded as a continuous whole. It is a perception of place that takes the form of gestures that connect them to their sense of being, and to locations that exist within and between their humanness and the natural world. It is a perception of body that comes to recognize the deep significance in the process of healing and reclamation of wholeness that is inherent in the experiential knowledge of being a diabetic person. And it is a perception of relationship that honors the diabetic self as an evolving identity entwined with a perception of relationship that honors the diabetic self, as well as an evolving identity entwined with a diabetic one, which expands outward to family, friends, and the community.

It was not until I spent time in First Nations communities as an outpost nurse, where I lived my life, in part, with aboriginal peoples that I began to observe personal lives in self-transformation, self-reflection, and self-learning. It was there that I developed an appreciation for diabetic issues and concerns within a context of cultural complexity. And it was an appreciation through which a true recognition of the cultural differences between colonial views of health and illness, and aboriginal views of healing and wellbeing, surfaced – a witnessing of culture as context and interaction.

There, with the nursing realities of sparse living conditions and historical and religious influences, is where I took deep interest in the ongoing quality of life. It enabled me to view myself positioned as a researcher alongside participants on a relational landscape. Thus, this inquiry into the aboriginal stories of diabetes had its beginnings in my practice of advanced nursing, which piqued a fascination for the circumstantial nature of our lives. And I began to listen to the storied experiences of others, like I have never listened before - actively, sensitively, emotionally, and viscerally.

The aboriginal experiences of diabetes are like the *seasons* – enfolding lessons over time. Like stories, not only do they remind us of past experiences; but they also renew, awaken, and honor natural life forces. Hence, almost every season that we experience explains the world to us, like stories that tell us what we need to know. It is the first day of spring, and everyone is talking about the rising river. Diabetes swirls in us with persistent movement, not unlike a river. For neither can a river hold its course, nor can chaotic diabetic moments. I contemplate something amiss as if it was the bank of the river flowing away like the unraveling of something familiar – the loose strands of my bodily existence. Some hard times are coming; you can scratch the itchiness in your skin so deep it leaves behind its restlessness. The Canada Geese flew away. I caught only a glimpse of them as shadowy figures flying away. I heard only the sounds that bellowed out as water and air were pushed aside. Out of the long evenings where pink lights left a softened sky I wanted to heave my intact body into a mountain for the mountain to keep, preserved in the budding birth and newness of a fresh day. But it was *the spring of my diabetes* and I saw the fledgling robin take a single leap into the air and drop. For in the distance I saw the face of diabetes turn, And I could not believe in that proverbial moment it had turned to look at me.

After the eggs had hatched and the river was full of fish, the *summer of my diabetes* was upon me. It revealed the shadow of a diabetic self. I had little desire to look at it. It reminded me of sad things. I struggled with it. I acted sick although I seldom felt sick. And where an emotional sickness had situated disharmonies alongside the important people in my life, I became stressed and confused. The Nuwalk life changes in summer.

The deer venture from the thick forest's mosquitoes to the open spaces of the valley floor. Tempered by breezy river shores that trail inland from the Pacific Ocean, visiting tourists snap their pictures there. I am in diabetic time now, beginning to see the connections. I want to feel reestablished in the world again. My body is pathetic. It was once so adept. I want my old life back. I need to listen, learn. I will listen to the spirit of the land, and visit places where I will remember myself, my surroundings, and my purpose in life. It is the most beautiful day of the year. The cloudless sky is a brilliant blue and mountains, trees, and wild things cut into the dry air and ground – illuminated not by light but by etched crisp edges of difference, hanging, existing. I circled back to my ancestral stories, my life stories. Something stirred in me - what diabetes stories am I going to tell my grandchildren?

Nature reveals and conceals, just like diabetes. It is the *autumn of my diabetes* and I feed my body as if I am healing it. I feel good today. I am learning to deal with what I do when it does not work. You cannot cheat the diabetes. The dark storms have started to come, pouring rain from heavy black clouds. I try to make sense again of my bewildered state. Diabetes is causing me to talk – the conversation of the body – and I begin to speak to my family and friends about exercise, body weight, and personal things. I notice where our truths and consoling are played out. I feel more emotional, sensitive. I am tired. I continue to struggle. The point is that I just do not know what the diabetic person is suppose to know; I just cannot see the concealed obvious that those in the know construct. We ask the white folks, “Are there snakes in that ravine?” “No. I haven't seen any.” And we come home having seen slithering pockets of the thriving young reptiles. Are there pine mushrooms on that mountain? Have the cougars had their young? Are there petroglyphs here? Where are the grease trails?

It is the first day of snow, and I am in the *winter of my diabetes.* Instead of staying in bed I get up, dismissing my diabetes as a chronic disease affecting a sick body. I am listening to what the health professionals are saying. I have to find the wisdom in it. I think the oolighan are trying to make a ‘come back’. There is a sad story. Like these little fish, stories speak of experience as ways of knowing. We must tell our stories - all kinds of stories. I learn from sharing my stories of diabetes with others. I am working on diabetes, figuring diabetes out. I have new ideas. I am thinking about being well in new ways. I am healing. It sometimes feels like trial and error. I still fall off the wagon, but I have changed my life in good ways. Today a heron stood in the shallows of our inlet. Its features and blue tone looked transparent in its stillness.

Professional Contributions

In considering the professional contributions, I present what the work furnishes in relation to what it means to health professionals. Reflections on practical issues arising from a concern for ethical issues and cultural pluralism, development of culturally competent knowledge, diabetes programs of care, and social health care policy are included. The fundamental emphasis of the health professions on understanding and treating diabetes (medicine) or understanding and treating human responses to diabetes (nursing) lends itself to a concern for aboriginal culture. Indeed, it has been primarily through nursing itself that I have discovered a deep interest in culture as an experiential phenomenon. In many ways, it is the complex concept of aboriginal culture that lies at the heart of the difference between understanding and treating diabetes, or understanding and treating human responses to diabetes, effectively and ineffectively.

When as health professionals we correct abnormal blood glucose levels, adjust oral glycemic medication or prescribe antibiotics for infection, the cultural influences on an aboriginal diabetic person are seldom given authentic consideration. I want to think that we are beyond the view that diabetes is diabetes whether it is managed in the city of Vancouver, the Bella Coola Valley, or rural British Columbia. But the reality is that because of our colonial tendency to focus on understanding diabetes through a lens of human physiology, we focus much less on understanding diabetes through a lens of relationality in the context of traditional and contemporary medicine.

The primary focus of health professionals is not just the provision of treatment per se, but the aboriginal person who decides to receive the treatment, implement the advice, and persist with the changes inherent in a challenging diabetic life. Nursing and the health professions, therefore, are profoundly influenced by ethical issues and cultural pluralism. Even in situations where traditional medicine has been severely colonized, there exists a context of traditional medicine where being diabetic, being aboriginal, and being well, is located. It is a diabetic being that is continuously played out in relation to interpreting diabetes as an unfolding ethical life. And it is in those interpretations where aboriginal interest in the effectiveness of traditional remedies for the management of symptoms related to being ill reveals aspects of cultural pluralism.

It is in the integration of ideas about aboriginal healing drawn from family and community medicine, and reflective of physical, mental, emotional, and spiritual wellbeing, with colonial medicine, that responses originate and are sometimes made visible. For aboriginal people learn to honor these connections between thinking and wisdom, and then act on those perceptions of body, mind, and emotion, deriving from the spirit their humanness that guides an understanding of diabetes. And it was by being with aboriginal people in all facets of storied life that the pages of diabetes stories were turned, together. They were stories within stories that spoke of ethical issues and cultural pluralism as a result of living with diabetes, whereby a humbling, compassionate, and honored existence became known. Thus, only slowly and gradually, and only with the patience and the desire to inquire narratively, did I succeed at revealing something of significance.

As aboriginal people are given a reason to share their life stories, a glimpse into their identity stories reveals an ethic guiding their humanness. It directs, in part, the colorful threads of a life – the depth of existence to live by, to be transformed by, and through transcendence, to be remembered by. And it is where such underlying principles of balance, harmony, and respect, common across the indigenous world, provide the foundation for the development of culturally competent knowledge and diabetes programs of care. Aboriginal life stories come as invitations to listen, and listen again, to aboriginal diabetic self-stories. They are stories that leave us with a deep sense of what it means for an aboriginal person to live a life through influences emanating from a context of traditional and contemporary medicine, where issues of self-government, socioeconomic development, and environmental protection are not separated from community health development. This is where aboriginal social health policy is best realized. Not in the inertia of broader social structural change, but in the changes that occur through community-based diabetic initiatives. Thus, the concept of diabetic healing, which integrates traditional medicine and professional services, is probably the most significant culturally safe development that could be made in the area of aboriginal people living with diabetes today.

As health professionals, we need to connect with aboriginal people living with diabetes, recognizing that each person is part of a family and a historical community – a place within the *stream of time.* We need to connect with families and communities in order to affirm, value, and include the language, cultural practices, and knowledge of the people in a meaningful way, in partnership, in order to build new relational practices that overcome the memories of past colonial remnants – *images of time.* We need to pay attention to the present realities of the communities where we practice and live. For we have a responsibility to participate in the creation of new possibilities for dialogue and conversation in ways that use narrative perspectives as paths to a deeper understanding of notions of reflection, experience, and relationship, as in the existential understanding of diabetes through *the sugar clock.* And because effective practices of health professionals take place in relationship with aboriginal people, who experience diabetes within an unfamiliar body, their broader existence and the complex historical contexts of culture, ancestry, and environment need to be kept in the forefront of our minds. Thus, we begin to negotiate a relationship with an aboriginal person in the midst of *feeding the diabetic body,* dealing with *exercise and body weight,* and trying to manage *body discomfort.* And we begin to explore in mutually respectful ways how to walk with them through intersections of multiple world views and perspectives in relation to *working on the diabetes* and *figuring the diabetes out.*

Personal Contributions

In considering the personal contributions, I discuss how my thinking of humanity as webs of significance that we ourselves spin, and as webs of significance that we ourselves are learning to spin differently, has broadened and deepened. Reflections on specific personal actions on how I will do things differently in nursing as a professional discipline are included. My experience as a narrative inquirer provided me with the opportunity to combine, rigorously and legitimately, my role as a researcher with my role as a fallible human being. It was a perspective from where I opened up to myself more vulnerable parts of my life, in order to be with my participants in ways that characterized a more personable researcher. As I listened, genuinely and intently, to their diabetic, social, and life stories, I thought of my own. Placing great importance on understanding and making meaning of their diabetic life experiences required sifting through the richness and intricacy of many lived stories - theirs, mine, and others on different relational landscapes. It is a realization that continues to provide me with energy to relate to others, with a desire to be connected in some way. Together, through our relatedness of thought and meaning, the co-participants and I came to understand and respect our interacting as powerful acts of intervening. Thus, such an experience of research assisted us to revisit stories from our past that were, sometimes, paradigm shifting and profound.

Some time later I, too, found it necessary to revisit one of my most profound personal stories – of redirecting the energy associated with the shame of an alcoholic mother to the constructive energies required in a career of nursing and academia. During this process of research, I was given another opportunity to recall how long it had taken to grieve the relationship I never had with my mother. It was in learning how to make my way in the world that I discovered a comfort in my own vulnerability that led me to a rich and sensitive life of relationships as friend, wife, and mother. Whether we realize it or not, like it or not, our stories are mixed with endless narrative threads of all our other stories – enveloping past and present stories into future stories.

By experiencing the condition of belonging to something bigger than the self, such a relational methodology helped us to know new aspects of ourselves as integral parts of the inquiry itself. It was for this reason that I found myself focusing on the productive, morally appropriate, and positive aspects of all our stories throughout the course of the inquiry. They were shared and hidden narratives that appeared different from each other, yet coalesced to form new pathways into understanding the relational characteristics of our changing and dynamic lives. They contained acts of relational significance that permeated all the events, happenings, attitudes, and feelings of our present lives; and illuminated, in new ways, those we have yet to discover in the future.

Specifically, it made me realize more profoundly how in need we are for places that provide useful ways of developing practical understandings among aboriginal peoples, health professionals, and others on various questions related to healing and wellbeing, including those focused on experiential and cultural exchanges. As the Royal Commission on Aboriginal Peoples emphasized, these aspects are closely related to addressing poor economic and environmental conditions, and social dislocation (RCAP, 1993). It was not uncommon for participants to converse about their childhood and how their ancestors survived through caring and sharing, and medicine provided by their community; nor was the recalling of a Nuxalk-specific context by which knowledge is passed down from one generation to another.

In the context-specific dialogue with my participants, there existed in their responses the creation of a supportive aboriginal diabetes context. They were suggestions that were most attentive to the features of honor and respect as formulated by aboriginal ways of knowing and being. For within these features was the idea of being ready to risk the loss of a familiar self as one who could view the self as rediscovered through a different self. And it caused me to explore the nuances to the meaning of understanding diabetes. I realized that each participant had deliberately let go of his or her familiar self, had experienced being lost at sea without an anchor as a result of the diabetes, but then had the internal and external resources to accept a different self – a diabetic self with whom each felt at home. In terms of us living the narrative inquiry together, it resulted in restorying a story to live by. Thus, an awareness of the experience of understanding ourselves as a process of sharing complex diabetes experiences was realized.

The tremendous value inherent within aboriginal diabetic social relationships was that the cooperation the participants developed and fostered with others provided a wide variety of benefits. Most significantly, they enabled people and groups to learn and share in diabetic resources and diabetic supports. Aboriginal people, whose spirituality and perspectives are deeply rooted in the land, have a unique set of principles that guide relationships with others. Strengthening people's diabetic cultural identities is closely associated with improving their overall health and strengthening the social and cultural fabric of their lives. This is where my interest in the pedagogic praxis of the inquiry lay, even though I was not an aboriginal person or experiencing diabetes directly myself.

Van Manen's (1997) words assist me to explain. They made me realize that as a human science researcher who is also a nurse, the participants and I could be considered as contributing to a pedagogic human science. And as his words resonated in me, it encouraged in us "a certain attentive awareness to the details and seemingly trivial dimensions of our everyday [listening, learning, and sharing] lives" (p. 8). It made me "thoughtfully aware of the consequential in the inconsequential, the significant in the taken-for-granted" (p. 8). To that end, it was a narrative inquiry based on hermeneutic phenomenological philosophy that reintegrated "part and whole, the contingent and the essential, value and desire" (p. 8). Thus, I cannot help but do things differently in nursing as a professional discipline, because I am no longer the same person I was when the inquiry began. I feel closer to being a whole person, and that is an important thing to be able to say.

Theoretical Contributions

An inquiry into the aboriginal stories of diabetes needs to be situated in the complexities of sociocultural realities. What such realities are socially significant to understanding aboriginal experiences of diabetes? Critical social theorists (Habermas, 1971; Freire, 1990) and postcolonial theorists (Bhabha, 1994; Thomas, 1994) would argue that in addition to cultural difference, an in-depth analysis would need to include the influence of the colonization and power relationships in which diabetes, healing, and wellbeing take place. In the inquiry, the stories of four people living with diabetes were presented in ways to illustrate how in their daily lives they attend to both culture and colonization. Each person in different ways integrated language and cultural knowledge and used cultural norms and values. In doing so, they developed more equitable relationships and processed the influences of colonization.

Within the stream of thought of critical social theory, elucidated is the potential development of a critical consciousness for all people within a shared view of the dialogical and developmental human being. The inquiry was reflective of participants' lives in terms of the social significance of the concept of self with the capacity to transform. By focusing on four aboriginal elders who were living with diabetes, a view of the transformative self could be seen within their positive, non-stereotyped construction of images, which revealed aboriginal reflections of *honoring the diabetic self.* They were people who passed on traditional knowledge, especially traditional healing knowledge, and who, through special connections to the healing spirit, helped in strengthening cultural identities, as well as diabetic ones. Significantly, they illuminated a notion of human enlightenment that was *walking in both worlds*, which was revealed to themselves and others as the capacity to engage effectively in culturally overlapping realities.

In terms of colonial power relationships within aboriginal stories of diabetes, evident were experiences and situations that revealed certain remnants in the relationships with health professionals, particularly during initial relational encounters. As a result, I recognized how the four participants sought places and ways to develop relationships outside the formal relationships of health and illness with their inherent or assumed hierarchical structure. Hospitals and clinics can be intimidating places for any diabetic, and especially for diabetics whose own healing experiences in such a context have not always been favorable, but rather, in some cases, painful. Remnants of past colonial relationships consisting of authority, control, and decision-making are vividly part of their memories, still occurring outside the traditional medicine system of their aboriginal community.

In contrast, these elders sought to form relationships that were more like partnerships, where *a diabetic self was revealed to others* – those people who could be trusted. I saw where traditional colonial relations between non-aboriginals and the community were being replaced by meaningful participation of the community in a school curriculum framed by language and culture, and by actively pursuing family involvement and support. Such strategies had transferred into *a diabetic sense of community*, which was a view of diabetes care and awareness located within teaching-learning-sharing relationships between diabetics, health professionals, and community members. It was based on a relational philosophy, whereby each person living with diabetes was part of a family and community. By using cultural norms in their life stories, the participants were sharing their influence in the diabetic stories they told by developing and respecting aboriginal beliefs and practices related to traditional medicine. Thus, brought to life were notions of aboriginal holism, the use of metaphors for thinking and speaking, and existential understandings of diabetes that included an understanding of time as *cultural time,* and place as the *resonance of lived space.*

In terms of the relational literature, I discovered amid indigenous scholarly writings, such as Battise (2000) and Smith (1999), a focus on social struggles that are enacted in social practices where aboriginal people can encounter an ethnocentric perspective, authoritative relationships, racist attitudes, and prejudicial beliefs about perceptions of inferiority or deficits. I realized that conditions such as these have been experienced in colonial systems of healthcare, causing some aboriginal people to resist the oppression by participating as little as possible.

George, Emilie, Violet, and Hazel, despite the obstacles, have succeeded and even excelled in acts of diabetic healing and wellbeing, in part, because they have told their stories of how they attended to issues of both culture and colonization. In a holistic way, their stories incorporated aboriginal culture, language, community norms, and values into their teachings. They did so in ways that developed mutually respectful relationships that helped them to process the influences of tragedy and hardship. It was not only what they did, but how they did it that was significant. Their stories tell of interrelationships and connections with people, not only to each other, but to a past as in an *echo of the past* and to present-day realities of *situation and experience.*

Their narratives are not complete, but are part of an ongoing discovery into how living with diabetes can overcome ineffective diabetic practices – stories in the midst, as lives always are unfolding. It is a discovery of how it can involve other diabetics, families, and communities in knowing a world of diabetes that is not only forgiving, but accommodating and gracious. Brought to life in their narratives were diabetic notions related to *time of play* and *gestures of empathic imagining.* It was within those notions that teachings of the four participants were revealed to others experiencing diabetes, along with respectful consideration for differing contextual relationships. Their stories advance practice and research in relation to the aboriginal experience of diabetes in ways that may be viewed in their entirety. For what happens in their narratives of diabetes cannot be separated from their daily lives with other diabetic people, families, friends, or the community in which they live. Thus, George, Emilie, Violet, and Hazel are *becoming the space they are in*, whereby the primary focus of diabetes as a practice of healing and wellbeing is in the creation of opportunities for listening, learning, and sharing on *landscapes of transformation.*

Informing Nursing Practice, Education, and Research

The Canadian Nurses Association (CNA) Position Statement on Promoting Culturally Competent Care (2004) views the responsibilities of individual nurses working with diverse cultures as acquiring, maintaining, and continually enhancing cultural competencies in relation to the clients for whom they care. They are responsible for incorporating culture into all phases of the nursing process and all domains of nursing practice. Those domains include: clinical practice (direct care), education, research, and administration.

Based on the findings of my dissertation work, in order for those responsibilities to be carried out with aboriginal people and communities experiencing diabetes, it is imperative that the following three philosophical tenets be embraced. First, it is essential to know how aboriginal people who are doing well living with diabetes are conversing about their experiences. Second, it is much more important to know the aboriginal person who is experiencing diabetes than it is to know what kind of diabetes the aboriginal person is exhibiting as an illness condition. Third, it is prudent that arguments to interpret wellbeing and diabetes care issues among aboriginal peoples be accompanied by explanations of life circumstances which originate from their own perspectives.

The dissertation informs nursing practice, education, and research through its approach in narrative form of the *aboriginal experiences of living with diabetes in ways that are profoundly different from non-aboriginal experiences as we think we know them.* The narrative inquiry explicates the cultural backgrounds of four significant aboriginal people living with diabetes. It includes their cultural, spiritual, and socioeconomic backgrounds and each one's influence on wellbeing and the healthcare system. It discusses how they are from a different aboriginal culture, and how they define health as *a sense of wellbeing*. Thus, through the co-construction of aboriginal life stories and diabetes stories, it informs nursing practice, education, and research by revealing what it is that should be known about aboriginal people who are living with diabetes, which will assist nurses to provide the best possible diabetes care.

The dissertation informs nursing practice, education, and research through its approach in narrative form of *how an existential understanding of diabetes in relation to time, place, body, and relationship creates a deeper connected sense with an aboriginal person's historical past, recent and present life.* The narrative inquiry provides background information on the changing aboriginal landscape in Canada, as well as consideration for the critical challenges these demographic shifts present to nurses and aboriginal diabetes clients. It discusses the key concepts associated with culturally appropriate healthcare, including considerations of human culture and cultural communication styles. It provides detailed dialogue on what nurses can base culturally-appropriate aboriginal diabetes service strategies. Thus, even though there may be no need for language interpreters, it informs nursing practice, education, and research by revealing the need for cultural interpreters in order to know how to work with aboriginal diabetic clients. Aboriginal people exhibit a diverse range of literacy in terms of the English language and mainstream white culture.

The dissertation informs nursing practice, education, and research through its approach in narrative form to *how mutual respect, as an aboriginal experience of being honored, may be understood as the ways in which a person thinks and behaves toward a person through acts of high regard that extend authentic caring to another person. And it may be experienced or expressed by each of two or more people about the other.* The narrative inquiry provides snapshots of the different cultural ways of relating that establish a basis for understanding how four aboriginal clients living with diabetes conceptualized wellbeing, and how they viewed institutions such as diabetes clinics and hospitals. It reveals their propensity to speak a native language, their different culturally-based views on life, and their beliefs that all people must be treated with respect. It discusses their belongingness to an ethnic group, the Nuxalk Nation, where people share a common language and variations of it, as well as culture and social views. Thus, their *ethnicity* did not rely on the physical characteristics of their people, but was closely related to cultural relations and how they developed a sense of identity as people and members of a group.

Lastly, the narrative inquiry informs nursing practice, education, and research with insights and in-depth cultural information from four aboriginal people experiencing diabetes, who revealed from their everyday life that which was so natural that it was easily forgotten. It is exactly those things that make up culture, which lead to the profound realization that tremendous variation *within* cultures and aboriginal populations, as well as *among* different cultures and aboriginal populations, exists. Thus, informing *nursing practice* is about the aboriginal experience of diabetes revealing culture as being passed from generation to generation, exhibiting a life of its own over time, and needing to be shared by everyone within the community. Informing *education* is about perceiving culture as flexible, where the culture that George, Emilie, Violet, and Hazel shared was one of ideas and values that people engaged in. It was a community that was able to change its values and behaviors to better meet a changing environment – *the experience of living with diabetes* – through being exposed to new and better ways of doing things by being part of the lives of others. Informing *research* is about approaching aboriginal people and communities with integrity and fidelity "based on ethical knowledge(s) and procedures which locate the protocols of working with aboriginal peoples within themselves" (Atkinson, 2002, p. 4).

Reflecting on Future Nursing Development

In my program of diabetes research, relationality within the inquiry represented an alternative culture of research for nursing science that generated representations of aboriginal people's *diabetic self* stories, and coaxed open a window for co-constructing a narrative about diabetes as a process of healing and wellbeing. It has opened up a desire to continue researching experience in terms of the whole issue of relationality, because it is either misunderstood or not understood. If it is a core construct for anyone, are we different from one another based on culture, along with other factors that make us different from one another? In considering a variety of research paradigms, I took the view that associated with beliefs about health and the fundamental human condition are appropriate methodologies that require serious reflection on diabetes and aboriginal peoples as context. And I took as axiomatic that the wellbeing of aboriginal peoples is the product of a complex web of physiological, psychological, spiritual, historical, sociological, cultural, economic, and environmental factors. How does nursing science assist us to understand the interconnected strands of this complex web?

As I have discussed, the ability to adapt a methodology for use in a cultural context, preserve the perspectives of aboriginal peoples, maintain the holistic nature of social problems, and value participation in respectful ways reflects strengths of an inquiry partial to a responsive and embodied scholarship. Given the social and moral mandates and theoretical requirements of nursing as a science, the ability to adapt a methodology for use in a cultural context is imperative. I propose that this inquiry, as a new way of researching diabetes, will stimulate discussion and critique of the alignment of our methodologies with outcomes that, along with yielding an intended set of knowledge claims, may also yield something else. As Clandinin and Connelly (2000) remark, "many narrative studies are judged to be important when they become literary texts to be read by others not so much for the knowledge they contain but for the vicarious testing of life possibilities by readers of the research that they permit" (p. 42).

Conclusion

As an interpretative account that holds onto its temporality and operates within its original context, *Spirit Winds: A Narrative Inquiry into the Aboriginal Stories of Diabetes* is presented in a way that strives to be understood as a whole piece of research text, being passed on along with its indigenous character so that it may be viewed as a grounded thesis. Taken together, the elicitation of aboriginal life stories and diabetes stories of four participants within a process of narrative inquiry provided an opportunity to look for material that supported alternate explanations within a cultural experience of diabetes. Each interpretation carried with it its plausibility in light of the provision of sufficient contextual evidence to support it. It was an inquiry that served to highlight the value of analyzing the stories from a universal, as well as local, level over a number of years. And it was a process that valued living with the stories and acknowledging the evolution of them over time, both through conducting further dialogue and conversation with participants, as well as through awareness of how the contexts within social, healing, and personal spheres change.

The process of translating aspects of aboriginal healing philosophy into practice involved the researcher's interpretation in co-participation with four aboriginal people living with diabetes. A synthesis and discussion of those interpretations through the contributions and reflections of cross-cultural, professional, and personal considerations revealed answers to questions of meaning about the storied knowledge landscape (Clandinin & Connelly, 2000) of the aboriginal diabetes experience in Canadian society. Such reflexivity revealed the participants' narratives of diabetes and exposed the creative responses and adjustments that existed in their diabetes and life experiences. It displayed the insights circumscribed by relationships, history, and the land, as well as new favorable constructions of aboriginal healing needs and identities, which contribute to improved aboriginal health generally. It puts forward a more balanced perspective of the aboriginal experience of living with diabetes in a thriving knowledge society. It is a location where opportunities to peer into the narrative spaces of understanding and explanation that emerge from identity stories make a difference in a world of growing cultural integration, increasing social complexity, and rapid technological change.

"*The world*", wrote the poet Rilke, "*is large, but in us it is deep as the sea*" (Campbell, 1991, p. 294). We carry the stories within us by which the world is held together. And we ourselves become less elusive. "In searching out its wonders, we are learning simultaneously the wonder of ourselves" (p. 294). My adoption story as a personal journey was chosen so that I might reach deeper into that wonder. The making and the way of being in this adoption story – the holding in one's arms – is for me transforming, deepening, and extending the embrace I have on the world and on those with whom it is shared. George, Emilie, Violet, Hazel and I adopted each other too, journeying together on a chosen path of narrative inquiry into the stories of diabetes. We embraced one another in the retelling of their diabetes and life stories as we attempted "to render life to modern lives" (p. 297). We cleansed the windows "of perception to the wonder, at once frightening and fascinating, of ourselves and of the universe of which we are the ears, the eyes, and the mind" (p. 298). And we courageously acted on our feelings throughout the duration of the inquiry that told us we were doing something important together.

We all sensed that the inquiry was going to be a memorable feature in our lives. It was as if, when we met, we already had the feeling that something of significance was about to transpire. It was an elusive feeling, but palpable somewhere in the first meeting. We chose to place our sensations and feelings outward, to be felt in between us, and to allow ourselves be guided by them. Living in our feelings, the richness and nuances of our experiences amidst reflective thinking were ready and waiting to be shared. With respect - looking again at each other - we chose to participate with one another. Perhaps, the only way we can converse about this ocean tide in which we are a participant is as Schopenhauer did: "the universe is a dream dreamed by a single dreamer where all the dream characters dream too" (Campbell, 1991, p. 133).

And so, to return to the elusive question that is raised: What are – or what are to be – those elements of a new cultural capacity within relational research? They are, perhaps, those subjective and elusive notions that become narratively renewed in the remembering of the present. And in our stories there are created sacred places where we are able to attend to the waking of one another in the knowledge of ourselves. Such an elusive landscape reminds me of the advice given to young Native Americans at the time of their initiations: “As you go the way of life, you will see a great chasm. Jump. It is not as wide as you think” (Campbell, 1991, p. 298).

The surface of the ocean has a shape, rolling consistently its peaked ridges - waves in a wind. Its changing shape is a familiar nuance on the landscape, among fish and ducks and other living things. Yet the water seeming to be there disappears. Scarcely a portion of it stays close to my immediate fleeting gaze. Everything the ocean consists of is altered with every sunset; only its entirety is recognized in ways that shape the surface where the motion of water is rhythmically stirred by the coming dawn. So, too, is the aboriginal experience of diabetes recognized in its fragments of completeness, and shaped as memories into spirit winds that call forth the aboriginal stories of diabetes.

References

American Diabetes Association (2000). Type 2 diabetes in children and adolescents. *Pediatrics, 105(3),* 671-680).

American Diabetes Association (2002). Evidence-based principles and recommendations for the treatment and prevention of diabetes and related complications. *Diabetes Care,* 25 *(Supplement 1),* S50-S60).

Anderson, J.F. (2000). Diabetes in aboriginal populations. *Canadian Medical Association Journal, 162(1)*, 11-12.

Archibald, J. (2001). Editorial: Sharing aboriginal knowledge and aboriginal ways of knowing. *Journal of Native Education, 25,* 1-5.

Bakan, D. (1996). Some reflections about narrative research and hurt and harm. In *Ethics and process in the narrative study of lives.* Edited by Ruthellen Josselson. Thousand Oaks: Sage Publications.

Barton, S.S, Anderson, N., & Thommasen, H.V. (2005). The diabetes experiences of aboriginal people living in a rural Canadian community. *Australian Journal of Rural Health, 13,* 242-246.

Bateson, M.C. (1994). *Peripheral visions: Learning along the way.* New York: Harper Collins.

Bateson, M.C. (2000). *Full circles overlapping lives: Culture and generation in transition.* New York: Random House.

Battiste, M. (1998). Enabling the autumn seed: Toward a decolonized approach to aboriginal knowledge, language, and education. *Canadian Journal of Native Education, 22,* 16-27.

Battiste, M. (2000). *Reclaiming indigenous voice and vision.* Vancouver: UBC Press.

Beauchamp, T.L., & Childress, J.E. (1994). *Principles of biomedical ethics.* New York: Oxford University Press.

Behar, R. (1996) *The vulnerable observer: Anthropology that breaks your heart.* Boston: Beacon Press.

Benyshek, D.C., Martin, J.F., & Johnson, C.S. (2001). A reconsideration of the origins of type 2 diabetes epidemic among Native Americans and the implications for intervention policy. *Medical Anthropology, 20*, 25-64.

Bhabha, H. (1994). *The location of culture.* New York: Routledge.

Bilu, Y. (1996). Ethnography and hagiography: The dialectics of life, story, and afterlife. In *Ethics and process in the narrative study of lives.* Edited by Ruthellen Josselson. London: Sage Publications.

Birchwater, S. (1993). *Ulkatcho: Stories of the grease trail.* Ulkatcho Indian Band, Anahim Lake, BC.

Blaise, C. (1993). *I had a father: A post-modern autobiography.* New York: Harper-Collins.

Bochner, A.P. (1997). It's about time: Narrative and the divided self. *Qualitative Inquiry, 3*, 418-438.

Boston, P., Jordan, S., MacNamara, E., Kozolanka, K., Bobbish-Rondeau, E., Iserhoff, H., Mianscum-Trapper, R., Mistacheesick, I., Petawabano, B., Sheshamush-Masty, M., Wapachee, R., & Weapenicappo, J. (1997). Using participatory action research to understand the meanings Aboriginal Canadians attribute to the rising incidence of diabetes. *Chronic Diseases in Canada, 18*(1), 5-12.

Briggs, C. (1986). *Learning how to ask: Sociolinguistic appraisal of the role of the interview in social science research.* Cambridge: Cambridge University Press.

Brink, P.J., & Wood, M.J. (1994). *Basic steps in planning nursing research.* Boston: Jones & Bartlett.

Buber, M. (1970). *I and thou.* New York: Scribner.

Bulmer, M. (1982). *Social research ethics.* London: Macmillan.

Burrows, N.R., & Geiss, L. (2000). Prevalence of diabetes among Native Americans and Alaskan Natives, 1990-1997: An increasing burden. *Diabetes Care, 23*(12), 1786-1790.

Butterfield, J. et al. (Eds.). (2003). *Collins English dictionary: Complete and unabridged.* (6th ed.). Glasgow: Collins.

Cajete, G. (1994). *Look to the mountain: An ecology of indigenous education.* Durango: CO: Kivaki Press.

Campbell, J. (1991). *Reflections on the art of living.* New York: HarperCollins Publishers.

Canadian Mental Health Association. (2002). *Creating a culturally inclusive organization: A resource action guide.* Retrieved August 1, 2005 from http://www.cmha.ca/english/info_centre/guides/books.htm

Canadian Nurses Association. (2004). *Position statement. Promoting culturally competent care.* Retrieved August 1, 2005 from http://www.cna-aiic.ca

Cardinal, D.J. (1996). *Keynote address.* Fourth Annual Conference of the Canadian Aboriginal Science and Technology Society, Vancouver, University of British Columbia.

Carr, D. (1986). *Time, narrative, and history.* Bloomington: Indiana University Press.

Carson, T. (1986). Closing the gap between research and practice: Conversation as a mode of doing research. *Phenomenology and Pedagogy, 4*(2), 73-85.

Carson, T. & Sumara, D. (eds.). (1997). *Action research as a living practice.* New York: Lang Publishing, Inc.

Carter, K. (1993) The place of story in the study of teaching and teacher education. *Educational Research, 22*, 5-12.

Clandinin, J., & Connelly, M. (2000). *Narrative inquiry: Experience and story in qualitative research*. San Francisco: Jossey-Bass.

Clifford, J. (1985). Introduction: Partial truths. In *Writing culture: The poetics and politics of ethnography.* Edited by James Clifford and George Marcus. Berkeley: University of California Press.

Cochran-Smith, M., & Lytle, S. (1993). *Inside/outside: Teacher research and knowledge.* New York: Teachers College Press.

Coles, R. (1989). *The call of stories: Teaching and the moral imagination.* Boston: Houghton Mifflin.

Conle, C. (1996). Resonance in preservice teacher inquiry. *American Educational Research Journal, 33*(2), 297-325.

Connelly, M., & Clandinin, J. (1988). *Teachers as curriculum planners: Narratives of experience.* New York: Teachers College Press.

Couture, J. (1991a). The role of native elders: Emergent issues. In J. Friesen (Ed.), *The cultural maze: Complex questions on native destiny in western Canada* (pp. 201-217). Calgary, AB: Detselig.

Couture, J. (1991b). Exploration in native knowing. In J. Friesen (Ed.), *The cultural maze: Complex questions on native destiny in western Canada* (pp. 53-73). Calgary, AB: Detselig.

Couture, J. (2000). Native studies and the academy. In G. Rosenberg et al. (Eds.), *indigenous knowledges in global contexts: Multiple readings of our world* (pp. 157-167). Toronto, ON: University of Toronto Press.

Coveney, P., & Highfield, R. (1990). *The arrow of time: A voyage through science to solve time's greatest mystery.* New York: Fawcett Columbine.

Crites, S. (1971). The narrative quality of experience. *Journal of the American Academy of Religion*, *39*, 291-311.

Dabelea, D., Hanson, R.L., Lindsay, R.S., Pettitt, D.J., Imperatore, G., Gabir, M.M., Roumain, J., Bennett, P.H., & Knowler, W.C. (2000). Intrauterine exposure to diabetes conveys risks for type 2 diabetes and obesity: a study of discordant sibships. *Diabetes, 49*(12): 2208-11.

Dabelea, D., Knowler, W., & Pettitt, D. (2000). Effect of diabetes in pregnancy on offspring: Follow-up research in the Pima Indians. *Journal of Maternal-Fetal Medicine, 9,* 83-88.

Daniel, M., & Green, L. (1995). Application of the Precede-Proceed planning model in diabetes prevention and control: A case illustration from a Canadian Aboriginal community. *Diabetes Spectrum*, *8*, 74-84.

Daniel, M., Green, L.W., Marion, S.A., Gamble, D., Herbert, C.P., Hertzman, C., & Sheps, S.B. (1999). Effectiveness of community-directed diabetes prevention and control in a rural aboriginal population in British Columbia, Canada. *Social Sciences and Medicine,* 48(6), 815-32.

de Courten, M., Hodge, A., Dowse, G., King, I., Vickery, J., & Zimmet, P. (1998). *Review of the epidemiology, aetiology, pathogenesis and preventability of diabetes in aboriginal and Torres Strait Islander populations.* Canberra: Commonwealth Department of Health and Family Services.

Deloria, E. (1990). *Waterlily.* Lincoln: University of Nebraska Press.

Denzin, N., & Lincoln, Y. (eds.) (1994). *Handbook of qualitative research.* Thousand Oaks, Calif: Sage.

Denzin, N., & Lincoln, Y. (1998). *The landscape of qualitative research: Theories and issues.* Thousand Oaks, CA: Sage Publications.

Dilthey, W. (1987). *Introduction to the human sciences.* Toronto: Scholarly Book Services.

Dreher, M., & MacNaughton, N. (2002). Cultural competence in nursing: Foundation or fallacy? *Nursing Outlook, 50,* 181-186.

Dyck, R.F., Klomp, H., Tan, L.K., Turnell, R.W., & Boctor, M.A. (2002). A comparison of rates, risk factors, and outcomes of gestational diabetes between aboriginal and non-aboriginal women in the Saskatoon health district. *Diabetes Care, 25*(3), 487-93.

Ellis, C. (1995). *Final negotiations: A story of love, loss, and chronic illness.* Philadelphia: Temple University Press.

Ermine, W. (1995). Aboriginal epistemology. In J. Barman, Y. Hebert & D. McCaskill (Eds.), *Indian education in Canada. Volume 1: The legacy* (pp. 101-112). Vancouver, B.C.: UBC Press.

Farook, V.S., Hanson, R.L., Wolford, J.K., Bogardus, C., & Prochazka, M. (2002). Molecular analysis of KCNJ10 on 1q as a candidate gene for type 2 diabetes in Pima Indians. *Diabetes, 51*(11): 3342-6.

Feldman, A. (1999). The role of conversation in collaborative action research. *Educational Action Research, 7*(1), 125-144.

Forbes, J. (1979). Traditional Native American philosophy and multicultural education. In *Multicultural education and the American Indian* (pp. 3-13). Los Angles, CA: University of California.

Frake, C. (1977). Plying frames can be dangerous: Some reflections on methodology in cognitive anthropology. *Quarterly Newsletter of the Institute for Comparative Human Development, 1*(3), 1-7.

Freire, P. (1973). *Education for critical consciousness.* New York: Seabury Press

Friere, P. (1985). *The politics of education: Culture, power and liberation.* (D. Macedo, Trans.). South Hadley, MA: Bergin & Garvey.

Friere, P. (1990). *Pedagogy of the oppressed.* New York: The Continuum Publishing

Company.

Gadamer, H.G. (1989). *Truth and Method.* trans. J. Weinsheimer & D.G. Marshall, 2nd rev. ed. New York: Crossroad. (Original work published in German in 1960; first English translation 1975).

Gaikezeheyongai, S. (2000). *Aboriginal-enhanced access to native learning.* Toronto: ON: Native Women's Resource Centre.

Gallagher, S. (1992). *Hermeneutics and education.* Albany: State University of New York Press.

Garro, L.C. (1995). Individual or societal responsibility? Explanations of diabetes in an Anishinaabe (Ojibway) community. *Culture, Medicine and Psychiatry, 40,* 37-46.

Geertz, C. (1973). *The interpretation of cultures.* New York: Basic Books.

Geertz, C. (1983). *Local knowledge: Further essays in interpretive anthropology.* New York: Basic Books.

Geertz, C. (1988). *Works and lives: The anthropologist as author.* Stanford: Stanford University Press.

Geertz, C. (1995). *After the fact: Two countries, four decades, one anthropologist.* Cambridge: Harvard University Press.

Geertz, C. (2000). *Available light: Anthropological reflections on philosophical topics.* Princeton, N.J.: Princeton University Press.

Gittelsohn, J., Harris, S.B., Burris, K., Kakegamic, L., Landaman, L.T., Sharma, A., Wolever, T.M.S., Logan, A., Barnie, A., & Zinman, B. (1996). Use of ethnographic methods for applied research on diabetes among the Ojibway-Cree in northern Ontario. *Health Education Quarterly, 23*(3), 365-82.

Gittelsohn, J., Wolever, T.M.S., Harris, S.B., Harris-Giraldo, R., Hanley, A.J.G., & Zinman, B. (1998). Specific patterns of food consumption and preparation are associated with diabetes and obesity in a Native Canadian community. *Journal of Nutrition, 128*, 541-7.

Goethe, W. (1963). *Goethe's world view, presented in his reflections and maxims.* New York: Frederick Ungar.

Goffman, E. (1959). *The presentation of self in everyday life.* New York: Doubleday.

Griffin, J.A., Gilliland, S.S., Perez, G., Upson, D., & Carter, J.S. (2000). Challenges to participating in a lifestyle intervention program: The Native American diabetes project. *Diabetes Educator, 26*(4): 681-9.

Guba, E.G., & Lincoln, Y.S. (1981). *Effective evaluation: Improving the usefulness of evaluation through responsive and naturalistic approaches.* Jossey-Bass, San Francisco.

Guba, E. & Lincoln,Y. (1989). *Fourth generation evaluation.* Newbury Park, CA, USA: Sage Publications.

Habermas, J. (1971). *Knowledge and human interests.* (J.J. Shapiro, Tras.) (1968). Boston: Beacon.

Hammersley, M. (1990). *Reading ethnographic research. A critical guide.* London: Longman.

Hanley, A., Harris, S., Barnie, A., Gittelsohn, J., Wolever, T., Logan, A., & Zinman, B. (1995). The Sandy Lake health and diabetes project: Design, methods and lessons learned. *Chronic Diseases in Canada, 16*(4), 149-56.

Health Canada. (2000). *Diabetes among aboriginal people in Canada: The evidence.* Ottawa: Health Canada.

Health Canada. (2003). *What determines health?* Retrieved August 1, 2005 from http://www.hc-sc.gc.ca/hppb/phdd/determinants/determinants.html

Hegele, R.A., Sun, F., Harris, S.B., Anderson, C., Hanley, A.J., & Zinman, B. (1999). Genome-wide scanning for type-2 diabetes susceptibility in Canadian Oji-Cree, using 90 microsatellite markers. *Journal of Human Genetics, 44*, 10-14.

Hegele, R.A. (2001). Genes, environment and diabetes in Canadian Aboriginal communities. *Advances in Experimental Medical Biology, 498,* 11-20.

Heilbrun, C. (1999). *Women's lives: The view from the threshold.* Toronto: University of Toronto Press.

Herbert, C. (1996). Community-based research as a tool for empowerment: The Haida Gwaii Diabetes Project example. *Canadian Journal of Public Health, 87,* 109-112.

Hernandez, C.A., Antone, I., & Cornelius, I. (1999). A grounded theory study of the experience of type 2 diabetes mellitus in First Nations adults in Canada. *Journal of Transcultural Nursing, 10*, 220-8.

Hollingsworth, S. (1994). *Teacher research and urban literacy education: Lessons and conversations in a feminist key*. New York: Teachers College Press.

hooks, b.(1989). *Talking back: Thinking feminist thinking black.* Boston, MA: South End Press.

hooks, b. (1997). *Wounds of passion: A writing life*. New York: Henry Holt & Company.

Huber, J. (2000). *Stories within and between selves: Identities in relation on the professional knowledge landscape.* Thesis (Ph.D.) University of Alberta.

Hulme, K. (1983). *The bone people.* Toronto: Penguin Books.

Hume, M. (1998). *River of the angry moon: Seasons on the Bella Coola.* Vancouver: Greystone Books.

Josselson, R. (1996). *Ethics and process in the narrative study of lives.* London: Sage Publications.

King-Hooper, B., Schulz, C., & Watts, J. (1995). A First Nations community-based diabetes education programme: The Nuu-Chah-Nulth experience. In: S. MacDonald, K. Anerson, and S. Roe-Finlay (Editors), *Diabetes and indigenous peoples: Theory, reality, hope* (pp. 91-95).

Kriska, A.M., Pereira, M.A., Hanson, R.L., de Courten, M.P., Zimmet, P.Z., Alberti, K.G., Chitson, P., Bennett, P.H., Narayan, K.M., & Knowler, W.C. (2001). Association of physical activity and serum insulin concentrations in two populations at high risk for type 2 diabetes but differing by BMI. *Diabetes Care, 24*(7), 1175-80.

Lafromboise, T., Trimble, J., & Mohatt, G. (1990). Counseling intervention and American Indian tradition: An integrative approach. *Counseling Psychologist, 18,* 628-654.

Langer, S. (1957). *Problems of art.* New York: Scribner.

Le Guin, U.K. (1989). *Dancing at the edge of the world.* New York: Harper & Row.

Le Sueur, M. (1990). Growth. In A. W. Schaef, *Meditations for women who do too much,* (pp. 354). San Francisco: HarperCollins Publishers.

Lieberman, L.S. (2003). Dietary, evolutionary, and modernizing influences on the prevalence of type 2 diabetes. *Annual Review of Nutrition, 23,* 345-377.

Lindsay, R.S., Funahashi, T., Hanson, R.L., Matsuzawa, Y., Tanaka, S., Tataranni, P.A., Knowler, W.C., & Krakaff, J. (2002). Adiponectin and development of type 2 diabetes in the Pima Indian population. *Lancet, 360*(9326), 57-8.

Maberley, D.A.L., King, W., & Cruess, A.F. (2000). The prevalence of diabetes in the Cree of western James Bay. *Chronic Diseases in Canada, 21*(3), 128-133.

Macaulay, A.C., Paradis, G., Potvin, L., Cross, E.J., Saad-Haddad, C., McComber, A., Desrosiers, S., Kirby, R., Montour, L.T., Lamping, D.L., Leduc, N., & Rivard, M. (1997). The Kahnawake Schools Diabetes Prevention Project: Intervention, evaluation and baseline results of a diabetes primary prevention program with a native community in Canada. *Preventive Medicine, 26,* 779-790.

Malinowski, B. (1922) *Argonauts of the Western Pacific.* London: Routledge.

McClure, L., Boulanger, M., Kaufert, J., & Forsyth, S. (1992). *First Nations urban health bibliography: A review of the literature and exploration strategies.* Northern Health Research Unit, Monograph Series No. 5, University of Manitoba, Winnipeg.

McComber, A., Macaulay, A., Kirby, R., Desrosiers, S., Cross, E., Saad-Haddad, C. (1996). The Kahnawake Schools Diabetes Prevention Project: Community participation in a diabetes primary prevention research project. *International Journal of Circumpolar Health*, 96, 370-374.

McIlwaith, T.F. (1948). *The Bella Coola Indians. Volume One.* Toronto: University of Toronto Press.

Meleis, A.I. (1996). Culturally competent scholarship: Substance and rigor. *Advances in* Nursing Science, *19*(2), 1-16.

Meltzer, S., Leiter, L., Daneman, D., Gerstein, H.C., Lau, D., Ludwig, S. (1998). 1998 clinical practice guidelines for the management of diabetes in Canada. *Canadian Medical Association Journal, 159*(Suppl. 8*),* S1-S29.

Merleau- Ponty, M. (1962). *Phenomenology of perception.* London: Routledge & Kegan Paul.

Miles, M.B., & Huberman, A.M. (1994). *Qualitative data analysis: An expanded sourcebook (2nd ed.).* Thousand Oaks, CA: Sage.

Mill, J., Allen, M., & Morrow, R. (2001). Critical theory: Critical methodology to disciplinary foundations in nursing. *Canadian Journal of Nursing Research, 33*(2), 109-127.

Mill, J.E., & Ogilvie, L.D. (2001). Ethical decision making in international nursing research. *Qualitative Health Research, 12*(6), 807-815.

Mood, L.J.L. (1975). *Rilke on love and other difficulties.* New York: Norton.

Morrison, N., & Dooley, J. (1996). The Sioux Lookout diabetes program: Diabetes prevention and management in northwestern Ontario. *International Journal of Circumpolar Health, 96,* 364-369.

Morrow, R.A., & Torres, C.A. (2002). *Reading Freire & Habermas: Critical pedagogy and transformative social change*. New York: Teachers College Press.

Morse, J.M., & Field, P.A. (1995). *Qualitative research methods for health professionals.* Sage: Thousand Oaks.

Murphy, E., & Dingwall, R. (2001). The ethics of ethnography. In P. Atkinson, A. Coffey, S. Delamont, J. Lofland, L. Lofland (Eds.), *Handbook of ethnography*. (pp. 339- 351). Thousand Oaks: Sage.

Neumann, A. (1997). Ways without words: Learning from silence and story in post-holocaust lives. In A. Neumann, & P. Peterson (Eds.), *Learning from our lives: Women, research, and autobiography in education.* (pp. 91-120). New York: Teachers College Press.

Nicolson, N., & Trautmann, J. (Eds.) (1973). The sickle side of the moon: The letters of of Virginia Woolf 1932-1935. London: The Hogarth Press.

O'Neil, J., Lechuk-Favel, L., Allard, Y., & Postl, B. (1999). Community healing and aboriginal self-government: Is the circle closing? In J. Hylton (Ed.), *Aboriginal self-government in Canada: Current trends and issues* (2nd ed.) (pp. 67-89). Saskatoon: Purich Publishing.

O'Neil, J.D. (1989). The cultural and political context of patient dissatisfaction in cross-cultural clinical encounters: A Canadian Inuit study. *Medical Anthropology Quarterly, 3*(4), 325-344.

O'Neil, J.D. (1986). The politics of health in the fourth world: A northern Canadian example. *Human Organization, 45*(2), 119-128.

Plummer, K. (2001). The call of life stories in ethnographic research. In P. Atkinson, A. Coffey, S. Delamont, J. Lofland, L. Lofland (Eds.), *Handbook of ethnography.* (pp. 395-406). Thousand Oaks: Sage.

Robinson, E.J., Gebre,Y., Pickering, J.L., Petawabano, B., Superville, B., & Lavallee, C. (1995). Effect of bush living on Aboriginal Canadians of the eastern James Bay region with non-insulin dependent diabetes mellitus. *Chronic Diseases of Canada, 16*(4), 144-8.

Rodrigues, S., Robinson, E., & Gray-Donald, K. (1999). Prevalence of gestation diabetes among James Bay Cree women in northern Quebec. *Canadian Medical Association Journal, 160*(9), 1293-7.

Royal Commission on Aboriginal Peoples (1993). *The path to healing: Report of the national round table on aboriginal health and social issues.* Ottawa: Canada Communication Group - Publishing.

Royal Commission on Aboriginal Peoples. (1997). *The final report of the Royal Commission on aboriginal peoples.* Chapter 3: Health and Healing. [CD-ROM]. Ottawa: Libraxus Inc.

Ryga, G. (1970). *The ecstasy of Rita Joe.* Vancouver: Talon Books.

Sandelowski, M. (1999). Focus on qualitative methods: Time and qualitative research. *Research in Nursing, 22,* 79-87.

Sarraute, N. (1990). Choices/Responsibility. In A. W. Schaef, *Meditations for women who do too much*, (pp. 55). San Francisco: HarperCollins Publishers.

Schon, D. A. (1991). *The reflective turn: Case studies in reflective practice.* New York: Teachers College Press.

Schultz, L.O. (1999). Traditional environment protects against diabetes in Pima Indians. *Healthy Weight Journal, 130*(5), 68-70.

Schwandt, T.A. (2001). *Dictionary of qualitative inquiry (2nd ed.).* London: Sage Publications.

Silko L. M. (1996). *Yellow woman and a beauty of the spirit.* Touchstone, New York.

Smith, D.G. (1994). *Pedagon: Meditations on pedagogy and culture.* Bragg Creek: Makyo Press.

Smith L. (1999). *Decolonizing methodologies: Research and indigenous peoples.* New York: University of Otago Press.

Soltis-Jarrett, V. (1997). The facilitator in participatory action research: Les raisons d'etre. *Advances in Nursing Science, 20*(2), 45-54.

Sommers, M.S., & Johnson, S.A. (1997). *Davis's manual of nursing therapeutics for diseases and disorders.* Philadelphia: F.A. Davis Company.

Spradley, J. (1979). *The ethnographic interview.* Toronto: Holt, Rhinehart & Winston.

Statistics Canada. (2001). *Visibility minority population, provinces and territories.* Retrieved August 1, 2005 from http://www.statcan.ca/english/Pgdb/demo40a.htm

Statistics Canada. (2001). *Profile of languages in Canada: Canada.* Retrieved August 1, 2005 from http://www12.statcan.ca/english/census01/products/analytic/companion/lang/canada.cfm

Stoddart, M.L., Blevins, K.S., Lee, E.T., Wang, W., & Blackett, P.R. (2002). Association of acanthosis nigricans with hyperinsulinemia compared with other selected risk factors for type 2 diabetes in Cherokkee Indians: The Cherokee diabetes study. *Diabetes Care, 5*(6), 1009-14.

Tafoya, T. (1995). Finding harmony: Balancing traditional values with western science in therapy. *Canadian Journal of Native Education,* 21(supplement), 7-27.

Thomas, N. (1994). *Colonialism's culture: Anthropology, travel and government.* Princeton, N.J.: Princeton University Press.

Torgovnick, M. (1996). *Crossing ocean parkway.* Chicago: University of Chicago Press.

Travers, K.D. (1995). Using qualitative research to understand the sociocultural origins of diabetes among Cape Breton Mi'kmaq. *Chronic Diseases of Canada, 16*, 140-3.

Valer, S. (2000). Optimal glycemic control in type 2 diabetic patients: Does including in treatment mean a better outcome? *Diabetes Care, 23*(Supplement 2), B30-B34.

Valvard, C. (1991). *Critical theory in health education.* Montreal: Montreal DSC (mimeo).

van den Berg, J.H. (1972). *A different existence.* Pittsburg: Duquesne University Press.

van Manen, M. (1998). *Researching lived experience: Human science for an action sensitive pedagogy.* London, ON: The Althouse Press.

Whelan, K. (2000). *Stories of self and other: Identities in relation on the professional knowledge landscape.* Thesis (Ph.D.) University of Alberta.

Whitehead, L. (2004). Enhancing the quality of hermeneutic research: Decision trail. *Journal of Advanced Nursing, 45*(5), 512-518.

Widdershoven, G., & Smits, M. (1996). Ethics and narratives. In *Ethics and process in the narrative study of lives.* Edited by Ruthellen Josselson. London: Sage Publications.

Wilson, S. (2003). Progressing toward an indigenous research paradigm in Canada and Australia. *Canadian Journal of Native Education, 27*(2), 161-178.

Young, T.K., Reading, J., Elias, B., & O'Neil, J. (2000). Type 2 diabetes mellitus in Canada's First Nations: Status of an epidemic in progress. *Canadian Medical Association Journal, 163,* 561-66.

Young, T.K, Waldrum, J.B., Herring, D.A., & Young, T.K. (1995). *Aboriginal health in Canada: Historical, cultural, and epidemiological perspectives.* Toronto: University of Toronto Press.

Ywahoo, D. (1990). Learning. In A. W. Schaef, *Meditations for women who do too much,* (pp. 244). San Francisco: HarperCollins Publishers.

Appendix A

Summary of Methods

Narrative inquiry provides a methodological framework and philosophy to guide the research process, as well as directs the methods that may be used (Clandinin & Connelly, 2000). Subject to review by the Health Research Ethics Board at the University of Alberta, adherence to the Royal Commission on Aboriginal Peoples (RCAP) Ethical Guidelines for Research (1993), and consideration for ethical issues arising from narrative inquiry practices and cross-cultural research, the purpose of the study is to understand Aboriginal people's experience of living with diabetes. Qualitative approaches, including conversation and dialogue, are the data collection methods chosen for the inquiry. Recruitment of a minimum of two women and two men of Aboriginal ancestry will be facilitated through close and trustworthy associates of the participants, residing in northern British Columbia, Canada. I anticipate engaging in a minimum of 5-6 audio-taped conversations with each participant that may last 1 ½ to 2 hours in order to contribute to an explorative study of experience related to diabetes. Following the analysis, all tapes will be erased and transcriptions will be kept for five years following the completion of the project.

The analysis of data will occur through an interpretive process of moving back and forth between field texts, interim research texts, and research texts shaped by questions of meaning and social significance. A synthesis of my own and four participants' life stories, and their experiences of diabetes that include identity and relational processes, will evolve into a co-constructed narrative about diabetes as a chronic illness. Relevant theory and literature used to frame the research findings will position the work further. As a method, critical theory, post-colonial studies, indigenous writings, empirical literature on diabetes, as well as lay literature on the aboriginal experience of diabetes will offer me a place to imagine my own uses and applications during the interpretive-analytic process.

Information Sheet (Participants)

Project Title: Spirit Winds - A Narrative Inquiry into the Aboriginal Stories of Diabetes
Sylvia Barton, RN, PhD Candidate, Faculty of Nursing ....Tel: (250) 960-6631
Linda Ogilvie, Associate Professor, Faculty of Nursing ....Tel: (780) 492-9109

This letter outlines important information that you will need to understand in order to decide whether or not you would like to be in this study. I am a graduate student in Nursing at the University of Alberta, Edmonton, Canada. I am doing research and would like to ask you to consider taking part in it. This study is to learn about the Aboriginal experience of living with diabetes. To be in this study you must be Aboriginal, living with diabetes for 5 years or more, and be over the age of 18 years.

If you agree to be in the study, I will ask you to participate in a minimum of 5-6 conversations, which will last about 1 ½ to 2 hours and that will be recorded on a tape recorder. I will talk with you about some of your life stories, as well as some of your stories that you may want to share about your experience living with diabetes. Our conversations will be completely private and your name will not be used in the study. The actual tapes will only be heard by myself and once they are typed onto paper will be destroyed. The typed record will be stored in a secure place by the researcher for five years following the end of the study and then destroyed. The typed record of our conversations may be used in future research after ethical approval is obtained. It may be used for the teaching of others or for writing articles.

I believe that our sense of whom we are and the experiences that we have are shaped by the stories we tell about ourselves. In total, I will participate separately with a minimum of two men and two women of Aboriginal ancestry who will respond to the question: **Looking back, what stories would you tell in order to explain your experiences of living with diabetes?** We will then talk with each other about these stories.

As a nurse who works with Aboriginal people, the benefits of this research will be around providing myself and other health care people with important understanding of how Aboriginal people make sense of their experiences while living with diabetes. By sharing our views with each other, findings from the research may help you to make clearer your personal and cultural strengths as an Aboriginal person living with diabetes. You may also have a chance to contribute to the development of knowledge that may help other Aboriginal people living with diabetes. A copy of the final study will be available to you upon request.

It is not expected that there will be any risk to you if you take part in the study. You may not receive any benefit from being in the study. The conversations only require your time. You may ask any questions that you have about the study. You are free to choose not to take part in the study. If you decide to be in the study and change your mind, you may withdraw from the study at any time and for whatever reason without penalty. You will not be pushed to share anything that causes you to feel uncomfortable. If issues do surface that are troublesome to you, we can talk about them further and, if necessary, help with a referral to counseling will be provided.

If you would like to participate in this study, please read and respond to the following questions. Then please sign your name below. Your signature will be proof that you have decided to participate in this research as an informed participant. If you have concerns about this study, you may contact Dr. Kathy Kovacs Burns, Research Director in the Faculty of Nursing at the University of Alberta, at (780) 492-3769. Do you have any questions?

Initials____________

CONSENT (Participants)

Part 1
Project Title: Spirit Winds - A Narrative Inquiry into the Aboriginal Stories of Diabetes
Sylvia Barton, RN, PhD Candidate, Faculty of Nursing ....Tel: (250) 960-6631
Linda Ogilvie, Associate Professor, Faculty of Nursing ....Tel: (780) 492-9109

Part 2
Do you understand that you have been asked to be in a research study? **Yes** **No**

Have you read and received a copy of the attached information sheet? **Yes** **No**

Do you understand the benefits and risks involved in taking part in this study? **Yes** **No**

Have you had the opportunity to ask questions and discuss this study? **Yes** **No**

Do you understand that you are free to refuse to participate or to withdraw from this study at any time? You do not have to give a reason. If you choose to withdraw from the study, do you understand that there would be no penalty? **Yes** **No**

Has the issue of the privacy of the conversations been explained to you? **Yes** **No**

If you agree to take part in this study, please sign your name below.

This study was explained to me by: ________________________

I agree to take part in this study

________________________ ____________ ____________________
Signature of Research Participant **Date** **Witness**

________________________ ____________________
Printed Name **Printed Name**

The consent has been obtained by the researcher below. I believe that the person giving consent understands what is involved in the study and voluntarily agrees to participate.

________________________ ____________
Signature of Researcher **Date**

Appendix B

CONSENT (Use of Participant's Name & Community)

Project Title: Spirit Winds - A Narrative Inquiry into the Aboriginal Stories of Diabetes
Sylvia Barton, RN, PhD Candidate, Faculty of Nursing ....Tel: (250) 960-6631
Linda Ogilvie, Associate Professor, Faculty of Nursing ....Tel: (780) 492-9109

Would you like your name to be used in the written form of this study? **Yes** **No**

Would you like the name of your community to be used in the written form of this study? **Yes** **No**

Would you like both your name and the name of your community to be used in the written form of this study? **Yes** **No**

If you agree to the use of your name and/or the name of your community in the written form of this study, please sign your name below.

This consent was explained to me by: ________________________

I agree to the use of my name and/or the name of my community in the written form of this study.

______________________	__________	______________
Signature of Research Participant	**Date**	**Witness**
______________________		______________
Printed Name		**Printed Name**

The consent has been obtained by the researcher below. I believe that the person giving consent understands what is involved in the study and voluntarily agrees to the above.

______________________	__________
Signature of Researcher	**Date**